

# Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care

## A Roadmap for Hospitals



## **Project Staff**

Amy Wilson-Stronks, M.P.P., Project Director, Health Disparities, Division of Quality Measurement and Research, The Joint Commission.

Paul Schyve, M.D., Senior Vice President, The Joint Commission

Christina L. Cordero, Ph.D., M.P.H., Associate Project Director, Division of Standards and Survey Methods, The Joint Commission

Isa Rodriguez, Project Coordinator, Division of Quality Measurement and Research, The Joint Commission

Mara Youdelman, J.D., L.L.M., Senior Attorney, National Health Law Program

## **Project Advisors**

Maureen Carr, M.B.A., Project Director, Division of Standards and Survey Methods, The Joint Commission

Amy Panagopoulos, R.N., M.B.A., Director, Division of Standards and Survey Methods, The Joint Commission

Robert Wise, M.D., Vice President, Division of Standards and Survey Methods, The Joint Commission

## **Joint Commission Mission**

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.

The inclusion of an organization name, product, or service in a Joint Commission publication should not be construed as an endorsement of such organization, product, or services, nor is failure to include an organization name, product, or service to be construed as disapproval.

© 2010 by The Joint Commission

Permission to reproduce this guide for noncommercial, educational purposes with display of attribution is granted. For other requests regarding permission to reprint, please call (630) 792-5954.

## **Suggested Citation**

The Joint Commission: *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL: The Joint Commission, 2010.

For more information about The Joint Commission, please visit <http://www.jointcommission.org>.



# Table of Contents

<b>Acknowledgements .....</b>	<b>vii</b>
<b>Introduction .....</b>	<b>1</b>
Terminology .....	1
A Roadmap to the Future .....	3
How the <i>Roadmap</i> Is Organized .....	3
Checklist of Recommended Issues to Address .....	4
Joint Commission Requirements .....	4
Laws and Regulations .....	4
Resource Guide .....	4
Suggested Ways to Use the <i>Roadmap for Hospitals</i> .....	4
To Improve Performance .....	4
To Train Staff .....	4
To Help Inform Policy .....	4
To Evaluate Compliance with Relevant Laws, Regulations, and Standards .....	6
<b>Chapter 1: Admission .....</b>	<b>9</b>
Recommended Issues and Related Practice Examples to Address During Admission .....	9
Inform patients of their rights .....	9
Identify the patient’s preferred language for discussing health care .....	10
Identify whether the patient has a sensory or communication need .....	10
Determine whether the patient needs assistance completing admission forms .....	11
Collect patient race and ethnicity data in the medical record .....	11
Identify if the patient uses any assistive devices .....	11
Ask the patient if there are any additional needs that may affect his or her care .....	11
Communicate information about unique patient needs to the care team .....	12
<b>Chapter 2: Assessment .....</b>	<b>13</b>
Recommended Issues and Related Practice Examples to Address During Assessment .....	13
Identify and address patient communication needs during assessment .....	13
Begin the patient–provider relationship with an introduction .....	14
Support the patient’s ability to understand and act on health information .....	14
Identify and address patient mobility needs during assessment .....	14
Identify patient cultural, religious, or spiritual beliefs and practices that influence care .....	15
Identify patient dietary needs or restrictions that affect care .....	16
Ask the patient to identify a support person .....	16
Communicate information about unique patient needs to the care team .....	16

**Chapter 3: Treatment.....17**

Recommended Issues and Related Practice Examples to Address During Treatment .....17

- Address patient communication needs during treatment .....19
- Monitor changes in the patient’s communication status .....19
- Involve patients and families in the care process .....19
- Tailor the informed consent process to meet patient needs .....19
- Provide patient education that meets patient needs .....20
- Address patient mobility needs during treatment .....21
- Accommodate patient cultural, religious, or spiritual beliefs and practices .....21
- Monitor changes in dietary needs or restrictions that may impact the patient’s care .....22
- Ask the patient to choose a support person if one is not already identified .....22
- Communicate information about unique patient needs to the care team .....22

**Chapter 4: End-of-Life Care .....25**

Recommended Issues and Related Practice Examples to Address During End-of-Life Care .....25

- Address patient communication needs during end-of-life care .....25
- Monitor changes in the patient’s communication status during end-of-life care .....26
- Involve the patient’s surrogate decision-maker and family in end-of-life care .....26
- Address patient mobility needs during end-of-life care .....27
- Identify patient cultural, religious, or spiritual beliefs and practices at the end of life .....27
- Make sure the patient has access to his or her chosen support person .....27

**Chapter 5: Discharge and Transfer .....29**

Recommended Issues and Related Practice Examples to Address During Discharge and Transfer .....29

- Address patient communication needs during discharge and transfer .....29
- Engage patients and families in discharge and transfer planning and instruction .....30
- Provide discharge instruction that meets patient needs .....30
- Identify follow-up providers that can meet unique patient needs .....31

**Chapter 6: Organization Readiness .....33**

Recommended Issues and Related Practice Examples to Address the Leadership Domain of Organization Readiness .....34

- Demonstrate leadership commitment to effective communication, cultural competence, and patient- and family-centered care .....34
- Integrate unique patient needs into new or existing hospital policies .....34

Recommended Issues and Related Practice Examples that Address the Data Collection and Use Domain of Organization Readiness .....35

- Conduct a baseline assessment of the hospital’s efforts to meet unique patient needs .....35
- Use available population-level demographic data to help determine the needs of the surrounding community .....36
- Develop a system to collect patient-level race and ethnicity information .....36
- Develop a system to collect patient language information .....36
- Make sure that the hospital has a process to collect additional patient-level information .....37

Recommended Issues and Related Practice Examples that Address the Workforce Domain of Organization Readiness .....37

- Target recruitment efforts to increase the pool of diverse and bilingual candidates .....37
- Ensure the competency of individuals providing language services .....38
- Incorporate the issues of effective communication, cultural competence, and patient- and family-centered care into new or existing staff training curricula .....38
- Identify staff concerns or suggested improvements for providing care that meets unique patient needs .....39

Recommended Issues and Related Practice Examples that Address the Provision of Care, Treatment, and Services Domain of Organization Readiness .....39

Create an environment that is inclusive of all patients .....	39
Develop a system to provide language services .....	40
Address the communication needs of patients with sensory or communication impairments .....	41
Integrate health literacy strategies into patient discussions and materials .....	42
Incorporate cultural competence and patient- and family-centered care concepts into care delivery .....	42
Recommended Issues and Related Practice Examples that Address the Patient, Family, and Community Engagement	
Domain of Organization Readiness .....	43
Collect feedback from patients, families, and the surrounding community .....	43
Share information with the surrounding community about the hospital's efforts to meet unique patient needs .....	43

**Appendix A: Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care Across the Care Continuum .....47**

**Appendix B: Current Joint Commission Requirements .....49**

Environment of Care .....	49
Emergency Management .....	50
Human Resources .....	50
Leadership .....	51
Provision of Care, Treatment, and Services .....	53
Rights and Responsibilities of the Individual .....	55
Transplant Safety .....	55

**Appendix C: New Joint Commission Standards .....57**

Human Resources .....	57
HR.01.02.01 .....	58
Provision of Care, Treatment, and Services .....	58
PC.02.01.21 .....	58
Record of Care, Treatment, and Services .....	60
RC.02.01.01 .....	60
Rights and Responsibilities of the Individual .....	61
RI.01.01.01 .....	61
RI.01.01.03 .....	62

**Appendix D: Laws and Regulations .....65**

Title VI of the Civil Rights Act of 1964: Language Access for LEP Persons .....	65
Revised HHS LEP Guidance – Effective Practices for Title VI Compliance .....	66
Complaint Investigation and Resolution .....	67
Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act: Effective Communication for People	
Who Are Deaf/Hard of Hearing .....	68
ADA Business Brief: DOJ Assistance for Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings .....	69
Settlements and Court Cases Involving Deaf or Hard-of-Hearing Persons in Hospital Settings.....	70
Section 504 of the Rehabilitation Act of 1973 and the ADA: Other Types of Prohibited Discrimination.....	72
Section 504 of the Rehabilitation Act of 1973 and the ADA: Accessible Medical Facilities and Equipment .....	73
Other Federal, State, and Local Laws .....	74
Title XVIII of the Social Security Act: Compliance with Federal Civil Rights Laws .....	74
Hill-Burton Act: Community Service Obligations .....	74
Age Discrimination Act of 1975 .....	75

Section 542 of the Public Health Service Act: Substance Abusers .....75  
State and Local Laws.....75

**Appendix E: Resource Guide .....77**

Leadership Domain .....77  
    Organization Assessment Using Frameworks, Tools, and Guidelines .....77  
Data Collection and Use Domain .....79  
    Collecting and Using Patient- and Community-Level Data for Service Planning .....79  
Workforce Domain .....80  
    Working with an Interpreter .....80  
    Cultural Competency Training .....80  
    Competencies for Interpreters and Translators .....82  
Provision of Care, Treatment, and Services Domain .....82  
    Improving Overall Patient–Provider Communication.....82  
    Developing Language Access Services for Patients Who Speak a Language Other Than English .....82  
    Translating Materials into Other Languages and Sources for Materials in Other Languages .....83  
    Respecting, Understanding, and Addressing Cultural Beliefs .....84  
    Addressing Religious and Spiritual Beliefs and Practices .....85  
    Addressing the Needs of Patients with Disabilities .....86  
    Addressing the Needs of Patients with Physical or Cognitive Communication Needs .....86  
    Addressing the Needs of Patients Who Are Blind or Have Low Vision .....86  
    Addressing the Needs of Patients Who Are Deaf or Hard of Hearing .....86  
    Addressing Health Literacy Needs .....87  
    Addressing the Needs of Lesbian, Gay, Bisexual, and Transgender Patients .....88  
    Providing Care at the End of Life .....88  
    Cultural Competency Materials for Specific Populations or Conditions .....89  
Patient, Family, and Community Engagement Domain .....89  
    Encouraging Patient and Family Engagement .....89  
    Engaging the Community .....90

**Glossary .....91**



# Acknowledgements

## Reviewers

Pat Adamski, Lynne Bergero, Shiva Bidar-Sielaff, Sarah Blackstone, Mary Brockway, Yue Pui Chin, Timothy Chu, Caroline Christensen, Marsha Connet, Margarete Cook, Ilene Corina, John Costello, Michele Erikson, Sheila Foran, Susan Frampton, Erica Galvez, Kathryn Garrett, Joel Ginsberg, George Handzo, Eileen Hanrahan, Romana Hasnain-Wynia, Amy Hasselkus, Richard Hurtig, Morgan Jones, Stephan Kamholz, Robert Katzfey, Joanna Kaufman, Kristi Kirschner, April Kopp, Debra Kreisberg, Karen Lee, Rebecca Mansbach, Deborah May, Julie McKinney, Mary Carol Mooney, Donise Mosebach, Sunita Mutha, Terri Parnell, Lance Patak, Harvey Pressman, Howard Rosenblum, Karin Ruschke, Laura Smith, Leslie Smith, Marjorie Stanzler, Joseph Swedish, Tristram Westphal, Sue Wintz, and Matthew Wynia

## Editorial and Production Support

Many thanks for the editorial support of Helen Fry, M.A., executive editor and Audrie Bretl Roelf, M.A., senior editor, Joint Commission Resources, and the design skills of Bridget Chambers, project manager, Joint Commission Resources.

## Special Thanks

We would like to thank Anne-Marie Audet, M.D., M.Sc., S.M., vice president, Quality Improvement and Efficiency at The Commonwealth Fund for her continued support.

We would also like to thank Anne Beal, M.D., M.P.H., president, Aetna Foundation for her support. Without her initial vision as Assistant Vice President at The Commonwealth Fund, we would not have been able to complete this project.

## Expert Advisory Panel

### Ignatius Bau, J.D.

Formerly with The California Endowment

### Shiva Bidar-Sielaff, M.A.

Director of Community Partnerships  
University of Wisconsin Hospital and Clinics

### Sheila M. Foran, J.D.

Senior Advisor, Office for Civil Rights  
U.S. Department of Health and  
Human Services

### Susan B. Frampton, Ph.D.

President  
Planetree

### Faye Gary, Ed.D., R.N., F.A.A.N.

Medical Mutual of Ohio Professor of Nursing for Vulnerable  
and At-Risk Persons  
Case Western Reserve University

### Joel Ginsberg, J.D., M.B.A.

Formerly with Gay and Lesbian Medical Association

### Malika Haque, M.D., F.A.A.P.

Physician/Pediatrician  
Nationwide Children's Hospital at The Ohio State University

### Romana Hasnain-Wynia, Ph.D.

Director, Center for Healthcare Equity  
Associate Professor, Research  
Northwestern University Feinberg School of Medicine

*A Roadmap for Hospitals*

**Elizabeth Jacobs, M.D., M.P.P.**

Associate Professor of Medicine  
Stroger Hospital of Cook County and Rush University  
Medical Center

**Stephan L. Kamholz, M.D., M.A.C.P., F.C.C.P.**

Chairman, Department of Medicine  
North Shore University Hospital and Long Island Jewish  
Medical Center

**Kristi L. Kirschner, M.D.**

Professor of Physical Medicine and Rehabilitation and  
Medical Humanities and Bioethics  
Northwestern University Feinberg School of Medicine and  
Schwab Rehabilitation Hospital of Chicago

**Debra Kreisberg, Ph.D.**

Director, Emergency Preparedness  
Colorado Hospital Association

**Deborah Ann May, R.N., B.S.N., M.B.A., C.D.P.**

Formerly with Jewish Hospital and St. Mary's HealthCare

**Sunita Mutha, M.D., F.A.C.P.**

Associate Professor of Medicine  
University of California, San Francisco

**Guadalupe Pacheco, M.S.W.**

Public Health Advisor/Special Assistant to the Director,  
Office of Minority Health  
U.S. Department of Health and Human Services

**Elda G. Ramirez, Ph.D., R.N., F.A.A.N.P.**

Nurse Practitioner  
University of Texas Health Science Center

**Jason R. Rau**

President  
NRC Picker

**Marsha Regenstein, Ph.D.**

Associate Research Professor, Department of Health Policy  
The George Washington University

**Karin Ruschke, M.A.**

President  
International Language Services, Inc.

**Fatema Salam, M.P.H.**

Formerly with National Quality Forum

**Carolyn R. Stern, M.D.**

Partner, DeafDOC.org  
Medical Director, Rochester School for the Deaf

**Joseph Swedish, M.H.A., F.A.C.H.E.**

President and CEO  
Trinity Health

**Debra A. Toney, Ph.D., R.N.**

President  
National Black Nurses Association

**Susan K. Wintz, M.Div., B.C.C.**

Board Certified Staff Chaplain  
St. Joseph's Hospital and Medical Center

**Ellen Wu, M.P.H.**

Executive Director  
California Pan-Ethnic Health Network

**Matthew K. Wynia, M.D., M.P.H.**

Director, The Institute for Ethics  
American Medical Association





# Introduction

Every patient that enters the hospital has a unique set of needs—clinical symptoms that require medical attention and issues specific to the individual that can affect his or her care. As patients move along the care continuum, it is important for hospitals to be prepared to identify and address not just the clinical aspects of care, but also the spectrum of each patient’s demographic and personal characteristics.

The nation’s hospitals traditionally focus on meeting the clinical needs of their patients; they seek to prevent errors and avoid inaccuracies that negatively impact the safety and quality of care. However, patients also have specific characteristics and nonclinical needs that can affect the way they view, receive, and participate in health care. A growing body of research documents that a variety of patient populations experience decreased patient safety, poorer health outcomes, and lower quality care based on race, ethnicity, language, disability, and sexual orientation [1-4]. As cultural, communication, mobility, and other basic patient needs go unmet, hospitals will continue to put themselves and their patients at risk for negative consequences. To improve the overall safety and quality of care provided in hospitals nationwide, health care organizations should aspire to meet the unique needs of their patients—patient by patient.

The Joint Commission has made several efforts, both past and present, to better understand individual patients’ needs and to provide guidance for organizations working to address those needs. The Joint Commission first focused on studying language, culture, and health literacy issues, but later expanded its scope of work to include the broader issues of effective communication, cultural competence, and patient- and family-centered care (see Table 1, page 2). No longer considered to be simply a patient’s right, effective communication is now accepted as an essential component of quality care and patient safety [5,6]. Additional studies show that incorporating the concepts of cultural competence and patient- and family-centeredness into the care process

can increase patient satisfaction and adherence with treatment [7,8].

## Terminology

A clear understanding of the concepts addressed in the *Roadmap for Hospitals* will ensure that the hospital is approaching effective communication, cultural competence, and patient- and family-centered care from the same perspective. The following terms are used frequently throughout this document.

- **Effective communication** The successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from patients, and when patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care.
- **Cultural competence** The ability of health care providers and health care organizations to understand and respond effectively to the cultural and language needs brought by the patient to the health care encounter. Cultural competence requires organizations and their personnel to do the following: (1) value diversity; (2) assess themselves; (3) manage the dynamics of difference; (4) acquire and institutionalize cultural knowledge; and (5) adapt to diversity and the cultural contexts of individuals and communities served [9].
- **Patient- and family-centered care** An innovative approach to plan, deliver, and evaluate health care that is grounded in mutually beneficial partnerships among

**TABLE 1: Joint Commission Efforts—Past and Present**

2003	In 2003, The Joint Commission conducted a gap analysis of its accreditation standards in comparison to the Office of Minority Health's <i>National Standards for Culturally and Linguistically Appropriate Services (CLAS)</i> [10]. The results indicated that although there were many Joint Commission standards that addressed the issues highlighted in the CLAS standards, the requirements were less prescriptive. Current Joint Commission standards can be found in Appendix B on page 49.
2004	The Joint Commission, with funding from The California Endowment, began the <i>Hospitals, Language, and Culture: A Snapshot of the Nation (HLC)</i> study in 2004. The HLC study was a qualitative cross-sectional research project that explored how 60 hospitals nationwide provide care to culturally and linguistically diverse patient populations.
2005	As part of a public policy initiative, The Joint Commission convened a Health Literacy and Patient Safety Roundtable in 2005. The Roundtable resulted in the publication of the white paper, <i>What Did the Doctor Say? Improving Health Literacy to Protect Patient Safety</i> [11]. This white paper presented recommendations and interventions to improve patient understanding of complex medical information for individuals with low health literacy or limited English proficiency (LEP).
2007	The HLC study released its first research report in March 2007, <i>Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings</i> [12]. The report provided insight into the challenges, activities, and perspectives of hospitals and contained recommendations for hospitals, policymakers, and researchers to improve care to diverse populations. Findings are presented within the context of a research framework, which includes the following domains: leadership, quality improvement and data use, workforce, patient safety and provision of care, language services, and community engagement.
2007	The Joint Commission received funding from The Commonwealth Fund to examine the characteristics (for example, impact, type, causes) of adverse events for LEP and English-speaking patients. Based on adverse event data from six Joint Commission-accredited hospitals, LEP patients were more likely to experience adverse events with detectable harm than English-speaking patients. The adverse events experienced by LEP patients were also more frequently caused by communication errors than for English-speaking patients. This study was published in the February 2007 <i>International Journal for Quality in Health Care</i> in an article titled "Language proficiency and adverse events in U.S. hospitals: A pilot study" [13].
2008	The second HLC report, <i>One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations</i> , presented current practices that hospitals are using to provide care and services to diverse patients [14]. This report, released in April 2008, includes a self-assessment tool that organizations can use to initiate discussions about their needs, resources, and goals for providing the highest quality care to every patient served.
2008	In 2008, The Joint Commission, with funding from The Commonwealth Fund, began the development of accreditation requirements for hospitals to advance the issues of effective communication, cultural competence, and patient- and family-centered care. The project was designed to improve the safety and quality of care for all patients through new and revised accreditation requirements and to inspire hospitals to adopt practices promoting patient-centered communication.
2009	In October 2009, The Joint Commission's Standards and Survey Procedures Committee of the Board of Commissioners approved new and revised standards for patient-centered communication. The new Joint Commission standards are discussed in detail in Appendix C on page 57.
2010	The Joint Commission published a monograph to help hospitals integrate communication, cultural competence, and patient- and family-centered care practices into their organizations. The monograph, titled <i>Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals</i> , was supported by a grant from The Commonwealth Fund.
2010	The Joint Commission continues to build its health equity work, specifically by convening an internal health equity advisory group and by initiating a project to understand how hospitals can provide patient- and family-centered care to lesbian, gay, bisexual, and transgender patients and families. This work is supported by a grant from The California Endowment.

health care providers, patients, and families. Patient- and family-centered care applies to patients of all ages, and it may be practiced in any health care setting [15].

## A Roadmap to the Future

The Joint Commission developed *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* to inspire hospitals to integrate concepts from the fields of communication, cultural competence, and patient- and family-centered care into their organizations. This monograph provides methods for hospitals to begin or improve upon their efforts to ensure that all patients receive the same high quality care.

A hospital must embed effective communication, cultural competence, and patient- and family-centered care practices into the core activities of its system of care delivery—not considering them stand-alone initiatives—to truly meet the needs of the patients, families, and communities served. The recommendations in the *Roadmap for Hospitals* do not encompass every aspect of these three areas, but they do represent key issues that hospitals should consider to meet the unique needs of each patient.

Recommendations and practice examples in this monograph address various issues including language, culture, health literacy, other communication barriers, mobility needs, and the concerns of lesbian, gay, bisexual, and transgender (LGBT) patients. As many of these issues can arise at various points along the care continuum, several recommendations are repeated to reinforce the importance of incorporating these practices into care delivery. Many of these recommendations originated during the development of the new patient-centered communication standards included in Appendix C on page 57. Example practices and “how to” information can help hospitals implement the recommendations and also comply with the new and existing Joint Commission requirements.

Each hospital has a different roadmap for advancing effective communication, cultural competence, and patient- and family-centered care. Because size, setting, and resources affect a hospital’s ability to create new services or modify existing programs, there is no “one size fits all” approach to these issues. This roadmap provides hospitals with direction and methods to begin or improve upon their efforts to meet the unique needs of their patients. The Joint Commission

encourages hospitals to adopt a combination of the practices discussed and to use these examples as a foundation for creating processes, policies, and programs that are best suited for their organizations.

The purpose of the *Roadmap for Hospitals* is to inspire hospitals to integrate concepts from the communication, cultural competence, and patient- and family-centered care fields into their organizations. Recommended issues to address, example practices, and “how to” information are included to help hospitals meet their patients’ unique needs.

## How the Roadmap Is Organized

To illustrate how the issues of effective communication, cultural competence, and patient- and family-centered care can be better incorporated into patient care, the *Roadmap for Hospitals* is structured around the main points along the care continuum. Each chapter presents a phase of the continuum and provides recommendations and practices for hospitals to address during that point in the care delivery process.

The chapters within the *Roadmap for Hospitals* address the following components of the care continuum:

- Chapter 1: Admission
- Chapter 2: Assessment
- Chapter 3: Treatment
- Chapter 4: End-of-Life Care
- Chapter 5: Discharge and Transfer
- Chapter 6: Organization Readiness

Each chapter in the *Roadmap for Hospitals* presents both recommended issues to address (with boxes) and practice examples (with round bullets):

### □ Recommended issues to address

These are broad, overarching concepts that hospitals should address to meet the unique needs of their patients.

- **Practice examples** provide “how to” information to help hospitals address the recommended issue. The example practices and methods represent the variety of ways a hospital can address the recommended issue; some may not apply to all hospital types, sizes, or settings. As there is no “one size fits all” solution, hospitals are encouraged to use the examples as a foundation for creating processes, policies, and programs that are best suited for their organizations.

## Checklist of Recommended Issues to Address

Each chapter of the *Roadmap for Hospitals* opens with a checklist of several recommended issues to address. The issues reflect recommendations from an expert advisory panel, and many of the practices and resources were collected during the development of the new patient-centered communication standards for hospitals. The complete checklist of all recommended issues included throughout this monograph can be found in Table 2, pages 5 and 6, and also appears as Appendix A on page 47.

## Joint Commission Requirements

The Joint Commission views effective communication, cultural competence, and patient- and family-centered care as important components of safe, quality care. Relevant Joint Commission standards and elements of performance that support the recommendations included in the *Roadmap for Hospitals* are presented in both Appendices B and C beginning on pages 49 and 57, respectively. Additional guidance on compliance and implementation of the new patient-centered communication standards is also provided.

## Laws and Regulations

There are a number of federal, state, and local laws that support the issues of effective communication, cultural competence, and patient- and family-centered care. Appendix D on page 65 presents the legal support for the recommendations and practice examples addressed in this *Roadmap for Hospitals*.

## Resource Guide

The *Roadmap for Hospitals* contains a list of additional resources that may be helpful as hospitals begin to implement the recommendations or continue in their efforts to address effective communication, cultural competence, and patient- and family-centered care. Links to supplemental information, model policies, and educational tools are provided to offer guidance and best practices from the field. Hospitals can build on these examples for new services or programs, modify the sample policies and tools to meet the needs of their patient populations, or contact other organizations and experts for further assistance. A compilation of these resources is provided in Appendix E on page 77.

## Suggested Ways to Use the Roadmap for Hospitals

Every organization's journey to improve communication,

cultural competence, and patient- and family-centered care will be unique. We have organized the *Roadmap for Hospitals* in such a way as to provide a comprehensive look at many of the systems and processes necessary to support effective communication, cultural competence, and patient- and family-centered care. Given each organization's unique needs, it will be vital that this monograph is used as a complement to existing efforts to monitor and improve quality and safety. To help hospitals embed quality and safety into all activities of the organization, some ideas for practical use of this monograph appear in the following sections.

## To Improve Performance

The Joint Commission recommends taking a comprehensive approach to each of the issues explored in the monograph. Hospitals should designate a dedicated group of individuals to review the monograph in its entirety. Ideally, individuals from a variety of disciplines across the organization will come together to discuss implications for the practices outlined in this monograph. Then, it may be useful to identify how the processes in the *Roadmap for Hospitals* are reflected in the hospital's current processes and pinpoint any gaps that may exist. The checklist in Table 2, pages 5 and 6, can be used as a quick reference to help catalogue your hospital's efforts to improve in the areas of effective communication, cultural competence, and patient- and family-centered care.

## To Train Staff

Hospitals may choose to distribute reading assignments from the *Roadmap for Hospitals* to key staff. For example, it may be important to have all quality, patient safety, and risk management staff read the content of the monograph so that they can incorporate relevant practices into their existing processes. Clinical staff may benefit from reading the core chapters to gain an understanding of how various patient-focused issues can be addressed throughout the continuum of care. This monograph could also be used as part of a comprehensive staff and medical staff orientation program.

## To Help Inform Policy

Some hospitals may want to use the *Roadmap for Hospitals* to evaluate policy and procedures. While the intent is not to focus on policy, well-crafted policy can support care practice that is effective and responsive to patient and clinician needs. Some of the areas that may be informed by the *Roadmap for Hospitals* include the patient satisfaction policy, visitation policy, interpreter service/language access policy, patient rights policy, complaint and grievance procedures, and so forth.

**Table 2. Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care Across the Care Continuum**

### Admission

- Inform patients of their rights.
- Identify the patient's preferred language for discussing health care.
- Identify whether the patient has a sensory or communication need.**
- Determine whether the patient needs assistance completing admission forms.
- Collect patient race and ethnicity data in the medical record.
- Identify if the patient uses any assistive devices.**
- Ask the patient if there are any additional needs that may affect his or her care.
- Communicate information about unique patient needs to the care team.**
- Ask the patient to choose a support person if one is not already identified.
- Communicate information about unique patient needs to the care team.**

### Assessment

- Identify and address patient communication needs during assessment.**
- Begin the patient-provider relationship with an introduction.
- Support the patient's ability to understand and act on health information.
- Identify and address patient mobility needs during assessment.
- Identify patient cultural, religious, or spiritual beliefs or practices that influence care.
- Identify patient dietary needs or restrictions that affect care.
- Ask the patient to identify a support person.
- Communicate information about unique patient needs to the care team.

### Treatment

- Address patient communication needs during treatment.**
- Monitor changes in the patient's communication status.**
- Involve patients and families in the care process.**
- Tailor the informed consent process to meet patient needs.
- Provide patient education that meets patient needs.
- Address patient mobility needs during treatment.
- Accommodate patient cultural, religious, or spiritual beliefs and practices.
- Monitor changes in dietary needs or restrictions that may impact the patient's care.

### End-of-Life Care

- Address patient communication needs during end-of-life care.**
- Monitor changes in the patient's communication status during end-of-life care.**
- Involve the patient's surrogate decision-maker and family in end-of-life care.**
- Address patient mobility needs during end-of-life care.
- Identify patient cultural, religious, or spiritual beliefs and practices at the end of life.
- Make sure the patient has access to his or her chosen support person.

### Discharge and Transfer

- Address patient communication needs during discharge and transfer.
- Engage patients and families in discharge and transfer planning and instruction.
- Provide discharge instruction that meets patient needs
- Identify follow-up providers that can meet unique patient needs.

### Organization Readiness

#### Leadership

- Demonstrate leadership commitment to effective communication, cultural competence, and patient- and family-centered care.
- Integrate unique patient needs into new or existing hospital policies.

#### Data Collection and Use

- Conduct a baseline assessment of the hospital's efforts to meet unique patient needs.
- Use available population-level demographic data to help determine the needs of the surrounding community.
- Develop a system to collect patient-level race and ethnicity information.

(continued on page 6)

**Table 2. Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care Across the Care Continuum (continued)**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Develop a system to collect patient language information.</li> <li><input type="checkbox"/> Make sure the hospital has a process to collect additional patient-level information.</li> </ul> <p><b>Workforce</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Target recruitment efforts to increase the pool of diverse and bilingual candidates.</li> <li><input type="checkbox"/> Ensure the competency of individuals providing language services.</li> <li><input type="checkbox"/> Incorporate the issues of effective communication, cultural competence, and patient- and family-centered care into new or existing staff training curricula.</li> <li><input type="checkbox"/> Identify staff concerns or suggested improvements for providing care that meets unique patient needs.</li> </ul> | <p><b>Provision of Care, Treatment, and Services</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Create an environment that is inclusive of all patients.</li> <li><input type="checkbox"/> Develop a system to provide language services.</li> <li><input type="checkbox"/> Address the communication needs of patients with sensory or communication impairments.</li> <li><input type="checkbox"/> Integrate health literacy strategies into patient discussions and materials.</li> <li><input type="checkbox"/> Incorporate cultural competence and patient- and family-centered care concepts into care delivery.</li> </ul> <p><b>Patient, Family, and Community Engagement</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Collect feedback from patients, families, and the surrounding community.</li> <li><input type="checkbox"/> Share information with the surrounding community about the hospital's efforts to meet unique patient needs.</li> </ul> |
|---|--|

## To Evaluate Compliance with Relevant Laws, Regulations, and Standards

The *Roadmap for Hospitals* was designed to help hospitals improve care. By focusing on this intent of the monograph, a hospital will also help ready itself for regulatory and compliance surveys. In addition to the information provided in the core chapters, many of the appendices provide additional compliance resources. Appendix B (page 49) includes an overview of current Joint Commission accreditation requirements for hospitals that support effective communication, cultural competence, and patient- and family-centered care. Appendix C (page 57) provides additional context and information about how The Joint Commission may evaluate compliance with the new patient-

centered communication standards. Appendix D (page 65) provides other supportive information including relevant laws and regulations. It explains what hospitals should do to be compliant with federal laws for language services, non-discrimination, and environmental accessibility.

The *Roadmap for Hospitals* provides a comprehensive view of many considerations to support effective communication, cultural competence, and patient- and family-centered care. We begin with chapters focused on points along the care continuum and practices that most directly impact the patient. However, appropriate organization systems and resources must be in place to support care practices. Therefore, it will be most effective for readers to consider the guide in its entirety.

## References:

1. Smedley B.D., Stith A.Y., Nelson A.R.: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academy Press, 2002.
2. Agency for Healthcare Research and Quality: *National Healthcare Disparities Report, 2006*. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2006. Available at <http://www.ahrq.gov/qual/nhdr06/nhdr06.htm>. (Accessed March 1, 2010.)
3. Office of the Surgeon General: *The 2005 Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities: What It Means to You*. Rockville, MD: U.S. Department of Health and Human Services, Office of the Surgeon General, 2005. Available at <http://www.surgeongeneral.gov/library/disabilities/calltoaction/whatitmeanstoyou.pdf>. (Accessed April 15, 2010.)
4. Delpertorio A.: *Healthcare Equality Index 2010*. Washington, DC: Human Rights Campaign Foundation and Gay and Lesbian Medical

- Association, 2010. Available at <http://www.hrc.org/documents/Healthcare-Equality-Index-2010.pdf>. (Accessed July 1, 2010.)
5. Divi C., Koss R.G., Schmaltz S.P., Loeb J.M.: Language proficiency and adverse events in U.S. hospitals: A pilot study. *Int J Qual Health Care* 19(2):60-67, Apr. 2007.
  6. Bartlett G., Blais R., Tamblyn R., Clermont R.J., MacGibbon B.: Impact of patient communication problems on the risk of preventable adverse events in acute care settings. *CMAJ* 178(12):1555-1562, Jun. 3, 2008.
  7. Wolf D.M., Lehman L., Quinlin R., Zullo T., Hoffman L.: Effect of patient-centered care on patient satisfaction and quality of care. *J Nurs Care Qual* 23(4):316-321, Oct.-Dec. 2008.
  8. La Roche M.J., Koinis-Mitchell D., Gualdrón L.: A culturally competent asthma management intervention: a randomized controlled pilot study. *Ann Allergy, Asthma Immunol* 96(1):80-85, Jan 2006.
  9. *What Is Cultural and Linguistic Competence?* February 2003. Agency for Healthcare Research and Quality, Rockville, MD. Available at <http://www.ahrq.gov/about/cods/cultcompdef.htm>. (Accessed March 1, 2010.)
  10. Office of Minority Health: *National Standards on Culturally and Linguistically Appropriate Services in Health Care*: Rockville, MD: U.S. Department of Health and Human Services, Office of Minority Health, 2001.
  11. Joint Commission on Accreditation of Healthcare Organizations (JCAHO): *“What Did the Doctor Say?”: Improving Health Literacy to Protect Patient Safety*. Oakbrook Terrace, IL: JCAHO, 2007. Available at [http://www.jointcommission.org/NR/rdonlyres/D5248B2E-E7E6-4121-8874-99C7B4888301/0/improving\\_health\\_literacy.pdf](http://www.jointcommission.org/NR/rdonlyres/D5248B2E-E7E6-4121-8874-99C7B4888301/0/improving_health_literacy.pdf). (Accessed April 15, 2010.)
  12. Wilson-Stronks A. Galvez, E.: *Hospitals, Language, and Culture: A Snapshot of the Nation Exploring Cultural and Linguistic Services in the Nation’s Hospitals: A Report of Findings*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2007. Available at [http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4DC4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4DC4ACD4BF8BD3/0/hlc_paper.pdf). (Accessed April 15, 2010.)
  13. Divi C., Koss R.G., Schmaltz S.P., Loeb J.M.: Language proficiency and adverse events in U.S. hospitals: A pilot study. *Int J Qual Health Care* 19(2):60-67, Apr. 2007.
  14. Wilson-Stronks A., Lee K.K., Cordero C.L., Kopp A.L., Galvez E.: *One Size Does Not Fit All: Meeting The Health Care Needs of Diverse Populations*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2008. (Available at [http://www.jointcommission.org/PatientSafety/HLC/one\\_size\\_meeting\\_need\\_of\\_diverse\\_populations.htm](http://www.jointcommission.org/PatientSafety/HLC/one_size_meeting_need_of_diverse_populations.htm). (Accessed April 9, 2010.)
  15. Institute for Family Centered Care: FAQ. Available at <http://www.familycenteredcare.org/faq.html>. (Accessed March 3, 2010.)







# Chapter One

## ADMISSION

The admission process is typically the initial point of contact a patient has with the hospital. Key patient information is collected during admission and used for identification, billing, and care planning purposes. In addition, patients receive a significant amount of information from the hospital, including patient rights documents and relevant hospital policies. As patients and their families interact with staff at the registration desk and complete admission forms and paperwork, the admission phase of the care continuum provides hospitals with the first opportunity to identify and address the unique needs of their patients.

This chapter focuses on the identification of several basic patient needs that must be addressed throughout the care continuum. Information regarding communication preferences and needs, cultural, religious or spiritual background, preferences and needs, mobility requirements, and other patient needs is essential for staff to help in the admission process to plan for appropriate services or accommodations. Any data collected during admission should be easily accessible at all points of care and in other relevant departments in the hospital.

Although the majority of patients will enter the hospital through the scheduled admission process, some patients will experience emergency admissions. For these patients, hospitals should adapt the recommendations included in this chapter to make sure that necessary patient-level data are collected by the clinical staff and that the hospital disseminates information to patients and families through alternative channels.

The next section includes both recommended issues to address during admission (with check boxes) and practice examples (with round bullets). While the recommended issues present broad, overarching concepts that all hospitals should address, the example practices and methods may not apply to all hospital types, sizes, or settings.

### ✓ Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care During Admission

- Inform patients of their rights.
- Identify the patient's preferred language for discussing health care.
- Identify whether the patient has a sensory or communication need.**
- Determine whether the patient needs assistance completing admission forms.
- Collect patient race and ethnicity data in the medical record.
- Identify if the patient uses any assistive devices.**
- Ask the patient if there are any additional needs that may affect his or her care.
- Communicate information about unique patient needs to the care team.

### Recommended Issues and Related Practice Examples to Address During Admission

#### Inform patients of their rights.

Several patient rights address the unique needs of individuals, such as the right to have a language interpreter, the right to receive accommodation for a disability, the right to be free from discrimination when receiving care, the right to identify a support person to be present during the hospital stay, and the right to designate a surrogate decision-maker. There are several ways to make sure that patients are informed of their rights in a manner that supports their involvement in their care, including the following:

- Post relevant hospital policies (in the most frequently encountered languages) in the waiting room.
- Include information about relevant hospital policies in patient Bill of Rights documents.
- Provide patient rights materials in multiple languages and alternative formats (for example, audio, visual, or written materials).
- Explain the right to have a language interpreter, the role of the interpreter in the health care encounter, and

that it is a free service provided for the safety of the patient.

- Explain the right to accommodation for individuals with disabilities and the services provided to help patients with communication needs or mobility issues.
- Explain the right to be free from discrimination, whether or not anti-discrimination protections are included in the specific state's laws and regulations, because hospital policy ensures the provision of equitable care to all patients.
- Explain the right to identify a support person, the purpose of the patient's support person (to relieve stress and provide emotional support), and the limitations if the presence of the support person infringes on others' rights, compromises safety, or is medically or therapeutically contraindicated.
- Explain the right to designate a surrogate decision-maker and that a surrogate decision-maker may be a family member, broadly defined to include friends and same-sex partners.\*

#### □ Identify the patient's preferred language for discussing health care.

Over 24 million people, or 8.7% of the American population, speak English less than very well and should be considered limited English proficient for health care purposes [1]. For patients that are minors or incapacitated, the preferred language of the patient's parent(s), guardian, or surrogate decision-maker should also be determined. As these individuals have the legal authority to make decisions on the patient's behalf, staff will need to meet the language needs of patient's parent(s), guardian, or surrogate decision-maker as well.†

- Ask the patient, "In what language do you prefer to discuss your health care?" The hospital should determine the preferred language of each patient,

regardless of whether the patient speaks English fluently or uses another language to communicate.

- Use a language identification card or tool to determine the patient's preferred language [2].
- Arrange for language services to help identify the patient's preferred language.‡
- Identify the preferred sign language for the patient who uses sign language to communicate (for example, American Sign Language, Signed English, or, for patients who are deaf or hard of hearing and have limited English proficiency, a sign language from another country).
- Note the patient's preferred language for health care discussions in the medical record and communicate this information to staff.

#### □ Identify whether the patient has a sensory or communication need.

Patients with pre-existing hearing, visual, or speech impairments may arrive at the hospital with their own communication aids or devices. For patients that experience sensory or communication impairment due to their current medical condition, it may be necessary for the hospital to provide auxiliary aids and services or augmentative and alternative communication (AAC) resources to facilitate communication.

- Ask the patient, "Do you have any hearing aids, glasses, or other devices that you routinely use in order to communicate?" If the patient has a personal aid or device, staff should ensure that the patient can access it at all times during the hospital stay.
- Contact an audiologist or involve the Ophthalmology Department, if possible, to provide the appropriate auxiliary aids and services needed to help a patient who has a sensory impairment due to a current medical condition during admission.§

\* This is a critical issue for lesbian, gay, bisexual, and transgender (LGBT) families. In some cases, biological family members may disapprove of the patient's same-sex relationship and may try to exclude the patient's partner from visitation or decision-making. If the couple is legally married in another state, the hospital should give the spouse the same rights as opposite sex spouses, even if the state in which the hospital is located does not permit or recognize same-sex marriages. As of March 2010, California, New Hampshire, Massachusetts, Connecticut, Iowa, Vermont, have permitted same-sex couples to marry. See the April 15, 2010 presidential memorandum respecting the rights of hospital patients to receive visitors and to designate surrogate decision-makers for medical emergencies regardless of their status of legally recognized immediate family members at <http://www.whitehouse.gov/the-press-office/presidential-memorandum-hospital-visitation>.

† See Chapter 6: Organization Readiness: Data Collection and Use (page 36) for more information on the collection of preferred language data.

‡ See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 40) for additional information on developing a system to provide language services.

§ See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 41) for additional information on providing auxiliary aids and services.

- Contact the Speech Language Pathology Department, if possible, to provide the appropriate AAC resources needed to help a patient who has a communication impairment due to a current medical condition.\*
- Note the sensory or communication need and mention any personal aids or devices, auxiliary aids or resources, or AAC resources in the medical record and communicate these needs to staff.

#### □ Determine whether the patient needs assistance completing admission forms.

Over 40% of adults have significant literacy challenges, and 88% of adults have less than “proficient” health literacy skills [3]. Recognizing that a patient needs help reading or completing admission forms can be a sensitive issue and staff should obtain necessary information without embarrassing the patient.

- Pay attention to clues to identify a patient with limited or low literacy (for example, statements like, “I forgot my glasses,” “My spouse usually keeps all this information at home,” or “Can I take this home to fill out and bring it back later?”) and respond with appropriate help.
- Ask the patient, “Would you prefer to have someone help you fill out the forms?”
- Offer the patient an opportunity to complete admission forms alongside a staff member.

#### □ Collect patient race and ethnicity data in the medical record.

Hospitals must collect patient-level demographic data on race and ethnicity to identify the needs of individual patients and to eliminate disparities in the patient population. These critical data provide hospitals with information on the potential cultural needs of each patient, as well as an opportunity to monitor and analyze health disparities at the population level.†

- Ensure that the patient understands why race and ethnicity data are being collected. The Health Research and Educational Trust recommends that staff explain to the patient, “We want to make sure that all our patients get the best care possible, regardless of their

race or ethnic background. We would like you to tell us your race or ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care” [4].

- Allow the patient to self-report race and ethnicity information.
- Respect the patient’s choice to decline to provide race and ethnicity information.
- Refer to hospital policies and procedures for collecting patient demographic data.

#### □ Identify if the patient uses any assistive devices.

A patient may arrive at the hospital with any of a number of devices that he or she uses to assist with activities of daily living and/or mobility. It is important for the hospital to make accommodations and make sure that the patient has access to these devices during care.

- Make sure that any needed assistive device (such as a service animal, cane, walker, wheelchair, or another mobility device) is available to the patient throughout the continuum of care.
- Identify whether specialized equipment should be used during the care of any patient with mobility needs.

#### □ Ask the patient if there are any additional needs that may affect his or her care.

Although many of the preceding points have addressed the identification of patient needs, there may be additional issues (such as cultural, religious or spiritual, mobility, or other needs) that would require staff to coordinate services, incorporate specialized equipment, or record supplementary information in the patient’s medical record.‡

- Ask a general question, “Is there anything else the hospital should be aware of to improve your care experience?”
- Identify whether the patient has cultural- or religion-based modesty issues regarding care provided by staff of the opposite sex.
- Determine if there are certain garments or religiously important items that need to be worn.

\* See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 41) for additional information on providing augmentative and alternative resources.

† See Chapter 6: Organization Readiness: Data Collection and Use (page 36) for more information on the collection of patient race and ethnicity data.

‡ See Chapter 6: Organization Readiness: Data Collection and Use (page 37) for more information on the collection of additional patient data.

- Note any additional needs in the medical record and communicate these needs to staff.

### □ **Communicate information about unique patient needs to the care team.**

Information on patient needs collected during admission can help staff coordinate communication assistance, plan for cultural or religious or spiritual accommodations, or provide necessary equipment throughout the care continuum.

- Note all relevant data in the patient's medical record.
- Create a process to identify any patients with unique needs (for example, color code the patient's chart, add flags or stickers to the patient's chart, or use patient armbands to denote different patient needs).
- Ensure that data collected during admission can be transferred to the clinical database for use at the point of care, especially if multiple data systems are used to capture patient information.

## References:

1. U.S. Census Bureau: American Community Survey, 2008 *American Community Survey 1-Year Estimates, S1601. Language Spoken at Home*. Washington, DC: U.S. Census Bureau, 2008. Available at <http://factfinder.census.gov>. (Accessed April 15, 2010.)
2. U.S. Department of Commerce Bureau of the Census: *Language Identification Flashcard*. Available at <http://www.justice.gov/cor/Pubs/ISpeakCards.pdf>. (Accessed March 1, 2010.)
3. White S., Dillow S.: *Key Concepts and Features of the 2003 National Assessment of Adult Literacy*. Washington, DC: National Center for Education Statistics, U.S. Department of Education, 2005. Available at <http://nces.ed.gov/NAAL/PDF/2006471.PDF>. (Accessed April 15, 2010.)
4. Hasnain-Wynia R., et al.: *Health Research and Educational Trust Disparities Toolkit*. Chicago, IL: Health Research & Educational Trust, 2007. Available at <http://www.hretdisparities.org>. (Accessed March 2, 2010.)



## Chapter Two

# Assessment

After a patient is admitted to the hospital, clinical staff conduct a clinical assessment to determine the care, treatment, and services that will meet the patient's needs. Staff should focus on collecting any clinical, environmental, demographic, or social information relevant to diagnose and treat the patient. Although several basic patient needs should be identified during admission, the assessment process provides an opportunity to probe potentially sensitive issues more deeply. Many factors can influence care and are important to consider. Some of these include the patient's health literacy, mobility, sexual orientation, gender identity and expression, cultural, religious, spiritual, lifestyle, or dietary needs.

This chapter highlights the importance of integrating effective communication, cultural competence, and patient- and family-centered care into the hospital's system of clinical patient assessment. The accuracy of assessment depends upon the accuracy of the information received, making effective patient-provider communication vitally important. Staff must make sure to address the patient's communication needs before conducting a comprehensive assessment or engaging the patient in care discussions.

The next section includes both recommended issues to address during patient assessment (with check boxes) and practice examples (with round bullets). While the recommended issues present broad, overarching concepts that all hospitals should address, the example practices and methods may not apply to all hospital types, sizes, or settings.

### ✓ Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care During Assessment

- Identify and address patient communication needs during assessment.
- Begin the patient-provider relationship with an introduction.
- Support the patient's ability to understand and act on health information.
- Identify and address patient mobility needs during assessment.
- Identify patient cultural, religious, or spiritual beliefs or practices that influence care.
- Identify patient dietary needs or restrictions that affect care.
- Ask the patient to identify a support person.
- Communicate information about unique patient needs to the care team.

### Recommended Issues and Related Practice Examples to Address During Assessment

- Identify and address patient communication needs during assessment.  
Provide appropriate communication assistance during the assessment process to meet the communication needs previously identified during the admission process and allow for accurate information exchange between the patient and provider. Patient communication needs and supports should be recorded in the patient's medical record, and any documented communication needs should trigger staff to arrange for the appropriate communication assistance.\*

\* See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 40 and 41) for additional information on providing language services, auxiliary aids, and augmentative and alternative communication resources.

- Check the patient's medical record to determine if any communication needs were previously identified, including the patient's preferred language and any sensory or communication needs.
- Arrange for language services during assessment to help patients whose preferred language is not English or who are deaf.
- Ensure that appropriate auxiliary aids and services are available during assessment for patients that have sensory impairments.
- Provide augmentative and alternative communication (AAC) resources for patients with communication impairments to help during assessment.
- Determine if the patient has developed a communication impairment since admission as a change in health status may impair the patient's ability to communicate. Provide AAC resources to help during assessment and contact the Speech Language Pathology Department, if available.
- Note the use of communication assistance in the medical record and communicate this need to staff.

#### □ Begin the patient–provider relationship with an introduction.

Individual providers can demonstrate sensitivity to the patient's needs and preferences by explaining his or her role on the care team and asking the patient how he or she prefers to be addressed.

- Make sure that all members of the care team introduce themselves to the patient and explain their role in the care process.
- Ask the patient, "Is the name on your chart the name you prefer?" or "Do you prefer to be addressed as Mr., Ms., Mrs., Dr., or Reverend; by your first name; or by any other preferred name or title?"
- Note the patient's preferred name prominently in the patient record to make sure that staff address the patient appropriately. Staff should be aware that patients who identify as transgender may have a name preference that differs from their legal name and may or may not have altered their bodies medically.
- Ask the patient if there are any cultural considerations for addressing the patient or his or her family members. For example, some cultures consider looking a person in the eye a sign of disrespect, while others value direct eye contact [1].

#### □ Support the patient's ability to understand and act on health information.

Patients with low health literacy may have great difficulty understanding their health information, participating in treatment decisions, and following through with treatment plans.

- Ask a health literacy screening question of the patient, such as "Do you need help understanding health care information?"
- Ask the patient how he or she prefers to receive information (for example, by reading, hearing, or viewing it).
- Speak in plain language instead of using technical terminology or medical jargon. Include examples and stories whenever possible.
- Use visual models, diagrams, or pictures to illustrate a procedure or condition.
- Help the patient gather basic health information by using a method such as AskMe3™, a strategy for asking and answering three questions about the patient's care [2].
- Use the "teach back" method to assess understanding by asking the patient to explain in his or her own words the information the staff provided or by asking the patient to demonstrate a skill that was taught.
- Refrain from simply asking the patient "Do you understand?" Regardless of their ability to understand the information, many people who do not understand may still answer "Yes."
- Encourage the patient to write notes on patient materials during discussions.

#### □ Identify and address patient mobility needs during assessment.

Many patients with mobility needs have difficulty physically accessing medical equipment. When specialized equipment is not available, staff may perform examinations and tests in a way that can generate inaccurate results or conceal physical evidence required for appropriate diagnosis and treatment, for example, conducting x-rays while the patient is seated in a wheelchair [3]. In addition, patients with unmet mobility needs due to a recent stroke, changes in health status, or treatment side effects may be at risk for falls.\*

- Assess whether the patient needs mobility assistance, including the type of and circumstances in which assistance is required.

\* See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (pages 39–40) for more information on ensuring that mobility assistance and specialized equipment are available.

- Make sure the patient has been assigned to a room that can accommodate his or her mobility needs.
- Make sure any mobility aid the patient uses (such as a service animal, cane, or walker) is readily accessible to the patient.
- Determine whether the patient requires accommodations (such as adaptive switches or an intercom call system) to access the nurse call system.
- Note the need for mobility assistance in the medical record and communicate these needs to staff.
- Make sure appropriate precautions are in place to prevent falls. Some hospitals post a sign above the patient's bed or door, or use special colored socks or bracelets to identify a patient at risk for falls.

#### □ Identify patient cultural, religious, or spiritual beliefs and practices that influence care.

Cultural, religious, or spiritual beliefs can affect a patient's or family's perception of illness and how they approach treatment. In addition, patients may have unique needs associated with their cultural, religious, or spiritual beliefs that staff should acknowledge and address.

- Ask the patient if there are any cultural, religious, or spiritual beliefs or practices that may influence his or her care.
- Ask the patient if the hospital environment is welcoming to their cultural and religious or spiritual beliefs. Some religious-based hospitals display items in patient rooms that reflect the organization's religious tradition and may conflict with the culture, religion, or spirituality of the patient and family. Consider removing the items, if possible, or covering them when necessary.
- Respect the patient's needs and preferences for modesty by assigning appropriate providers, uncovering only the parts of the body necessary for examination and treatment, providing privacy in toileting and washing, and using full gowns or robes for walking and transport. Many cultures and religions have restrictions on touching, distance, and modesty, which may be affected by providers of the opposite sex or staff that are younger or older than the patient.
- Determine if the patient uses any complementary or alternative medicine or practices. Consider



#### Helpful Tip: Understanding the Patient's Perspective

Arthur Kleinman developed a clinical model aimed at creating a shared understanding between patient and provider. The model maintains that caregivers can identify cultural- or religion-based beliefs and practices by asking questions about the patient's perspective of his or her illness and use the answers to create a treatment plan. The model includes the following types of questions:

- What do you think has caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you? How does it work?
- How severe is your sickness? Will it have a short or long course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?

**Reference:** Kleinman A., Eisenberg L., Goode B.: Culture, illness and care: Clinical lessons from anthropologic and cross cultural research. *Ann Intern Med* 88(2): 251–258, Feb. 1978.

incorporating these into the patient's care, if appropriate.

- Consult a professional chaplain, if available, to complete a spiritual assessment. The chaplain may have screening questions to identify religious practices, relaxation techniques, and other coping resources that may influence care.
- Provide an area or space to accommodate the patient's need to pray. In addition, ask the patient if there are specific times of day to avoid scheduling tests or procedures in order to respect the patient's religious or spiritual practices.
- Note any cultural, religious, or spiritual needs that influence care in the medical record and communicate these preferences to staff.

### □ Identify patient dietary needs or restrictions that affect care.

Dietary needs and restrictions can arise from cultural, religious, or spiritual practices, or they may be related to the patient's medical condition. Some medications use animal byproducts as binders and fillers, and staff should be aware of the patient's dietary restrictions in order to select alternative medications where possible.

- Ask the patient "Is there anything your providers should be aware of regarding your diet?"
- Identify whether the patient's religious or spiritual beliefs or customs require or forbid eating certain foods.
- Determine if the patient routinely or periodically observes fasting practices (for example, on religious holidays).
- Note the dietary needs or restrictions in the medical record and communicate them to staff.
- Make sure the hospital's food service accommodates the patient's needs.

### □ Ask the patient to identify a support person.

A patient support person should provide emotional support, give comfort, and alleviate fear during the course of the patient's hospital stay. Patients should have access to their chosen support person at all times.

- Explain the purpose of the patient's support person, including limitations if the presence of the individual infringes on others' rights, compromises safety, or is medically or therapeutically contraindicated.

- Make staff aware that the patient has chosen a support person to be present with him or her during the course of stay.
- Allow the patient access to the support person at all times.\*
- Ask if the patient would like to involve the chosen support person during rounds, patient education, and other crucial decision-making and care processes. The support person may or may not be the patient's designated surrogate decision-maker.
- Note information about the patient's support person in the medical record and communicate the selection to staff.

### □ Communicate information about unique patient needs to the care team.

Any information about patient needs should be easily accessible at all points of care and in other appropriate departments to help staff provide the necessary services and arrangements to meet patient needs.

- Note all relevant data in the patient's medical record.
- Create a process to identify any patients with unique needs (for example, color code the patient's chart, add flags or stickers to the chart, or use patient armbands to denote different patient needs). Consider posting signs on doors or above the patient's bed, or using the whiteboard in the patient's room to communicate, with the patient's permission, information to staff.
- Inform staff of patient needs at specific transfer points, including transports for procedures, tests, or transfers to different care units or services.

## References:

1. HealthCare Chaplaincy: *A Dictionary of Patients' Spiritual and Cultural Values for Health Care Professionals*. New York: HealthCare Chaplaincy, Updated Sept. 2009. Available at <http://www.healthcarechaplaincy.org/userimages/doc/Cultural%20Dictionary.pdf>. (Accessed March 1, 2010.)
2. Partnership for Clear Health Communication: *Ask Me 3: What Can Providers Do?* Boston: National Patient Safety Foundation, 2009. Available at [http://www.npsf.org/askme3/\PCHC/what\\_can\\_provid.php](http://www.npsf.org/askme3/\PCHC/what_can_provid.php). (Accessed March 1, 2010.)
3. National Council on Disability: *The Current State of Health Care for People with Disabilities*. Washington, DC: National Council on Disability, 2009. Available at <http://www.ncd.gov/newsroom/publications/2009/pdf/HealthCare.pdf>. (Accessed March 1, 2010.)

\* On April 15, 2010, President Obama released a presidential memorandum for the secretary of the Department of Health and Human Services respecting the rights of hospital patients to receive visitors and to designate surrogate decision-makers for medical emergencies regardless of their status of legally recognized immediate family members (available at <http://www.whitehouse.gov/the-press-office/presidential-memorandum-hospital-visitation>). (Accessed on July 22, 2010.)





## Chapter Three

# Treatment

Staff identify many of the patient's unique needs during admission and assessment, and it is important for hospitals to address those needs while providing care, treatment, and services. It is equally important to recognize that needs may change during the course of treatment. This stage of the care continuum allows hospitals to integrate effective communication, cultural competence, and patient- and family-centered care into discussions about treatment options, risks, and alternatives. In addition, hospitals should be prepared to adapt existing processes and procedures to meet patient needs through the duration of treatment, which can vary from days to weeks.

Before engaging the patient in care planning discussions, the hospital must address the patient's communication needs. The patient has to be able to understand his or her health information and fully participate in the conversation so that the hospital may obtain informed consent, provide patient education, or accommodate any unique needs.

The next section includes both recommendations for hospitals to promote patient and family involvement in the treatment process (with check boxes) and practice examples (with round bullets). While the recommended issues present broad, overarching concepts that all hospitals should address, the example practices and methods may not apply to all hospital types, sizes, or settings.

### ✓ Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care During Treatment

- ❑ Address patient communication needs during treatment.
- ❑ Monitor changes in the patient's communication status.
- ❑ Involve patients and families in the care process.
- ❑ Tailor the informed consent process to meet patient needs.
- ❑ Provide patient education that meets patient needs.
- ❑ Address patient mobility needs during treatment.
- ❑ Accommodate patient cultural, religious, or spiritual beliefs and practices.
- ❑ Monitor changes in dietary needs or restrictions that may impact the patient's care.
- ❑ Ask the patient to choose a support person if one is not already identified.
- ❑ Communicate information about unique patient needs to the care team.

### Recommended Issues and Related Practice Examples to Address During Treatment

- ❑ Address patient communication needs during treatment.  
Communication assistance is needed during treatment to meet the communication needs previously identified during admission and assessment. Record this information in the patient's medical record so that any documented communication needs trigger staff to arrange for the appropriate communication assistance.\*

\* See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 40 and 41) for additional information on providing language services, auxiliary aids, and augmentative and alternative communication resources.

- Check the patient's medical record for any identified communication needs, including the patient's preferred language and any sensory or communication impairments.
- Arrange for language services to help with treatment of patients whose preferred language is not English or who are deaf.
- Make sure that appropriate auxiliary aids and services are available during treatment of patients who have sensory impairments.
- Provide augmentative and alternative communication (AAC) resources to help with treatment of patients with communication impairments.
- Note the use of communication assistance in the medical record and communicate needed aids and services to staff.

#### □ Monitor changes in the patient's communication status.

A change in health status or the outcome of a medical treatment or procedure can impair the patient's ability to communicate. Patients may develop new or more severe communication impairments over the course of care, and staff should periodically assess for changes in the patient's communication status (see Figure 5-1, Sample Tool for Communication Assessment, page 19).

- Determine if the patient has developed new or more severe communication impairments during the course of care and contact the Speech Language Pathology Department, if available. Provide AAC resources, as needed, to help during treatment.
- Anticipate the communication needs of the patient who is expected to develop communication impairments from scheduled treatment or procedures (for example, as a result of intubation, tracheostomy, sedation, or other interventions that may compromise the patient's ability to communicate). In addition, consider whether bed positioning or the placement of medical equipment for treatments or procedures will impede the patient's use of required AAC resources.
- Note any changes in the patient's communication status in the medical record and communicate new needs to staff.

#### Involve patients and families in the care process.

Staff must involve both the patient and his or her family to develop a treatment plan that is tailored to the patient's unique needs. Staff should encourage the patient and family to ask questions throughout the course of care and provide opportunities for them to participate in care discussions.

- Ask the patient which, if any, family members he or she would like to involve in care discussions. Family members may be broadly defined to include friends and same-sex partners.\* Staff should discuss a child's care with both parents, including same-sex parents.
- Adapt existing hospital procedures to better involve the patient and family in care discussions. For example, consider rescheduling patient rounds or making sure the information provided to the patient during rounds is available to the patient's family members at a later time.
- Urge patients to take a role in preventing health care errors by becoming active, involved, and informed participants on the health care team. The Joint Commission, together with the Centers for Medicare and Medicaid Services, has a national Speak Up™ program which features brochures, posters, and buttons on a variety of patient safety topics [1].
- Consider providing communication assistance to family members whose preferred language is not English or who have sensory or communication impairments to facilitate family involvement in care discussions.†
- Make sure that appropriate communication supports are in place during care discussions; family and friends should not be used to interpret.
- Notify the patient and family of ongoing opportunities to ask questions. Encourage the patient and family to write down questions for discussion with caregivers.

#### □ Tailor the informed consent process to meet patient needs.

The informed consent process allows patients and providers to establish a mutual understanding about the care, treatment, and services the patient will receive.

\* Family involvement is a critical issue for lesbian, gay, bisexual, and transgender (LGBT) patients and families. In some cases, biological family members may disapprove of the patient's same-sex relationship and may try to exclude the patient's partner from visitation or decision making. Exclusion of a primary caregiver may compromise patient adherence with treatment recommendations. When treating children with same-sex parents, staff should include both parents in discussions about the child's health care, even if both do not have legal custody.

† See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 40 and 41) for additional information on providing language services, auxiliary aids, and augmentative and alternative communication resources.

**Figure 5-1. Sample Tool for Communication Assessment****Patient Communication Assessment Tool****Baseline Communication Method/Special Needs**

- 1) Verbal
- 2) Writing (Pen & Paper)
- 3) Communication Board
- 4) Electronic Communication Device
- 5) **Speaking Valve**
- 6) Gesturing
- 7) Mouthing/Lip Reading
- 8) Hearing Aids
- 9) Glasses
- 10) Language Interpreter Needed
- 11) Family Facilitated
- 12) Sign Language Interpreter Needed
- 13) Other (document explanation)

**Assessment**

*Patient's reported level of distress with communication [scale 0-5]*

- 0) Not at all
- 1) A little bit
- 2) Somewhat
- 3) Quite a bit
- 4) Very much
- 5) No response

**Current Barriers**

- 1) Hostility
- 2) Withdrawn/Depressed
- 3) Delirium
- 4) Agitation
- 5) Confusion
- 6) Impaired LOC\*
- 7) Illiterate
- 8) Orally Intubated
- 9) Trached
- 10) Foreign Language
- 11) Sedated
- 12) Restrained
- 13) Surgery
- 14) History of Stroke
- 15) Weakness
- 16) Vision Impairment
- 17) Hearing Impairment
- 18) Visitation Restrictions
- 19) Other (document explanation)
- 20) None

\* LOC, level of consciousness

**Source:** Modified from Patak L., et al.: Improving patient-provider communication: A call to action. *J Nurs Adm* Sep 2009; 39(9):372-376. Used with permission.

**Interventions at Point of Care**

- 1) Comfort Measures
- 2) Music
- 3) Sitter
- 4) Communication Device (document explanation)
- 5) Phone
- 6) Speaking Valve
- 7) Calm Spoken Voice
- 8) Give Patient Time to Communicate
- 9) Released Restraints
- 10) Glasses
- 11) Hearing Aid
- 12) Call Light
- 13) Interpreter
- 14) Other (document explanation)

**Re-Assessment**

*Patient's reported level of distress with communication [scale 0-5]*

- 0) Not at all
- 1) A little bit
- 2) Somewhat
- 3) Quite a bit
- 4) Very much
- 5) No response

**Evaluation/Effectiveness**

- 1) Patient reports being satisfied
- 2) Family reports being satisfied
- 3) Patient reports being unsatisfied
- 4) Family reports being unsatisfied
- 5) Patient responds appropriately with intervention
- 6) Necessary information is obtained from and provided to the patient
- 7) Patient demonstrates understanding
- 8) Other (document explanation)

**Referral**

- 1) Yes (document explanation)
- 2) No

*Use an assessment tool to identify any changes in communication needs and include the results in any hand-off reports. This sample patient communication assessment tool was designed to be incorporated into computerized charting menus to help nurses select drop down items which corresponded to their patient communication assessment, intervention, and evaluation process.*

Address the patient's unique needs and preferences during the discussion and incorporate them into relevant written materials and forms. This supports the patient's ability to understand and act on health information.

- Ask the patient how he or she prefers to receive information (for example, by reading, hearing, or viewing).
- Speak in plain language and avoid using technical terminology or medical jargon. Include examples and stories whenever possible.
- Use visual models, diagrams, or pictures to illustrate a procedure or condition.
- Help the patient gather basic health information by using methods such as AskMe3™, a strategy for asking and answering three questions about the patient's care [2].
- Use the “teach back” method to assess understanding. This involves asking the patient to explain in his or her own words the information that the staff shared or asking the patient to demonstrate a skill that was taught.
- Refrain from simply asking the patient “Do you understand?” Regardless of their ability to understand the information, many people who do not understand may still answer, “Yes.”
- Notify the patient of ongoing opportunities to ask questions. Encourage the patient to write notes or check off key information on patient materials during discussions.
- Use informed consent materials that meet health literacy needs. Materials should be written at a 5th grade or lower reading level. Consider revising written materials to address the health literacy needs of all patients. Use readability tests, divide complex information into bullet points, and modify document font, layout, and design improve readability.\*
- Use translated informed consent materials in the patient's language whenever possible. Provide an interpreter for the patient's preferred language during informed consent discussions, even if the hospital provides translated materials, to facilitate patient communication.†
- If translated documents are not available, interpreters should not attempt a sight translation; instead the clinician should obtain the patient's consent verbally.



### Helpful Tip: Translate Documents for Informed Consent

Hospitals cannot expect interpreters to be able to sight translate (that is, express verbally what is in the written text) a complex legal document into the patient's preferred language. Sight translation requires a different skill set than verbal interpretation. To avoid errors and poor translations, hospitals should obtain written translations and not rely on interpreters to sight translate informed consent documents.

The National Council on Interpreting in Health Care recommends professional translation for legal documents such as consent forms for the following reasons:

- Formality of the language and complexity of a text with many legal terms
- Many health care interpreters lack familiarity with legal terminology and there is a resulting risk for inaccuracies if required to translate on site
- The inability of many patients to understand and retain information provided during a long and complex sight translation

**Reference:** National Council on Interpreting in Health Care: *Sight Translation and Written Translation: Guidelines for HealthCare Interpreters*. Working Paper Series. Washington, DC: National Council on Interpreting in Healthcare, April 2009. Available on [http://data.memberlinks.com/site/ncihc/Translation\\_Guidelines\\_for\\_Interpreters\\_Final042709.pdf](http://data.memberlinks.com/site/ncihc/Translation_Guidelines_for_Interpreters_Final042709.pdf). (Accessed March 1, 2010.)

- Note the receipt of informed consent and any communication assistance used to obtain it in the medical record.

### □ Provide patient education that meets patient needs.

Patient education discussions and materials should be modified to the patient's ability to understand and act on health information.

- Ask the patient how he or she prefers to receive information (for example, by reading, hearing, or viewing).

\* See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 42) for additional information on integrating health literacy strategies into patient discussions and materials.

† See Appendix D: Laws and Regulations (page 67) for additional information on what documents require translation.

- Speak in plain language and avoid using technical terminology or medical jargon. Include examples and stories whenever possible.
- Use visual models, diagrams, or pictures to illustrate a procedure or condition.
- Help the patient gather basic health information by using methods such as AskMe3, a strategy for asking and answering three questions about the patient's care [2].
- Use the “teach back” method to assess understanding. This involves asking the patient to explain in his or her own words the information the staff shared or asking the patient to demonstrate a skill that was taught.
- Refrain from simply asking the patient “Do you understand?” Regardless of their ability to understand the information, many people who do not understand may still answer “Yes.”
- Encourage the patient to write notes or check off key information on patient education materials during discussions.
- Use patient education materials that meet health literacy needs. Materials should be written at a 5th grade or lower reading level. Consider revising written materials to address the health literacy needs of all patients. Use readability tests, divide complex information into bullet points, and modify document font, layout, and design to improve readability.\*
- Use translated patient education materials in the patient's language whenever possible. Provide an interpreter for the patient's preferred language during patient education discussions, even if the hospital provides translated materials, to facilitate patient communication.

#### □ Address patient mobility needs during treatment.

Many patients with mobility needs have difficulty physically accessing medical equipment. When specialized equipment is not available, staff may conduct examinations and tests in a way that can generate inaccurate results or conceal physical evidence required for appropriate diagnosis and treatment, for example, conducting x-rays while the patient is seated in a wheelchair [3]. In addition, patients with unmet mobility

needs due to a recent stroke, changes in health status, or treatment side effects may be at risk for falls.†

- Assess whether the patient needs mobility assistance, including the type of and circumstances in which assistance is required.
- Make sure the patient has been assigned to a room that can accommodate his or her mobility needs.
- Make sure any mobility aid the patient uses (such as a service animal, cane, or walker) is readily accessible to the patient.
- Determine whether the patient requires accommodations (such as adaptive switches or an intercom call system) to access the nurse call system.
- Make sure appropriate precautions are in place to prevent falls. Some hospitals post a sign above the patient's bed or door, or use special colored socks or bracelets to identify a patient at risk for falls.
- Note the need for mobility assistance in the medical record and communicate these needs to staff.

#### □ Accommodate patient cultural, religious, or spiritual beliefs and practices.

The patient's beliefs and practices can affect the perception of illness and how he or she approaches treatment. Staff should accommodate the patient's unique needs whenever possible.

- Communicate any cultural, religious, or spiritual beliefs or practices staff identified during the admission or assessment process to the care team.
- Respect the patient's needs and preferences for modesty by assigning appropriate providers, uncovering only the parts of the body necessary for examination and treatment, providing privacy in toileting and washing, and using full gowns or robes for walking and transport. Many cultures and religions have restrictions on touching, distance, and modesty, which may be affected by providers of the opposite sex or staff that are younger or older than the patient.
- Provide an area or space to accommodate the patient's need to pray. In addition, ask the patient if there are specific times of day to avoid scheduling tests or procedures to respect the patient's religious or spiritual practices.
- Work with the patient and family to develop mutually agreed on solutions to patient requests regarding

\* See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 42) for additional information on integrating health literacy strategies into patient education discussions and materials.

† See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (pages 39–40) for more information on making sure that mobility assistance and specialized equipment are available to patients.



### Helpful Tip: Visits in the Intensive Care Unit

Patients in the intensive care unit (ICU) are particularly vulnerable, may feel isolated, and commonly have complex communication needs. Many ICU patients are intermittently or continually intubated, may require the use of a continuous or bi-level positive airway pressure (CPAP or Bi-PAP) machine, or may be at various levels of sedation. These patients must have unrestricted access to their chosen support person while in the ICU to provide emotional and social support. In addition, the presence of a surrogate decision-maker to participate in care discussions and advocate on behalf of the patient is vital for the patient who is unconscious and unable to speak for him or herself.

cultural, religious, or spiritual beliefs or practices. For example, in some cultures, the patient's family may want to light candles under the patient's bed. The use of candles may not be permitted in the hospital; however, one potential compromise is to suggest that the family use battery operated flashlights instead of candles.

- Note any cultural, religious, or spiritual needs that influence the patient's care in the medical record and communicate patient preferences to staff.

### □ Monitor changes in dietary needs or restrictions that may impact the patient's care.

Dietary needs and restrictions should be identified during the admission and assessment processes, but new needs and restrictions may arise because of the patient's medical condition or during the course of treatment.

- Inform the patient of any new dietary needs or restrictions based on his or her treatment or medications.
- Note emergent dietary needs or restrictions in the medical record and communicate changes to staff.
- Notify the hospital's food service to accommodate the patient's needs.



### Example Practice: Identifying Patients with Communication Needs

The family of a profoundly deaf woman reported that environmental services staff had not attended to the patient's room. Specifically, the bathroom had not been serviced and the trash had not been emptied. The environmental service provider reported that nobody responded each time she knocked on the door. Not wanting to disturb or wake a sleeping patient, she proceeded to the next patient room.

While direct care staff were aware through chart review of the patient's communication needs, other providers—whose service contributes to the patient's quality of care and comfort—were unaware of her impaired hearing status. To address this, the hospital created a universal tracking symbol for hearing status and placed an 'ear' on the door of hearing impaired patients to alert all staff of the patient's status.

### □ Ask the patient to choose a support person if one is not already identified.

Patients should have an opportunity to identify an individual to provide emotional support, give comfort, and alleviate fear during the course of the patient's hospital stay. The patient's needs may change along the care continuum, and a patient who did not choose a support person at admission or assessment may choose to do so at any point during the course of treatment.

- Explain the purpose of the patient's support person, including limitations if the presence of the individual infringes on others' rights, compromises safety, or is medically or therapeutically contraindicated.
- Make staff aware the patient has chosen a support person to be present during the course of stay.
- Allow the patient access to the support person at all times.
- Ask if the patient would like to involve the chosen support person during rounds, patient education, and other crucial decision making and care processes. The support person may or may not be the patient's designated surrogate decision-maker.\*

\* On April 15, 2010, President Obama released a presidential memorandum for the secretary of the Department of Health and Human Services respecting the rights of hospital patients to receive visitors and to designate surrogate decision-makers for medical emergencies regardless of their status of legally recognized immediate family members (available at <http://www.whitehouse.gov/the-press-office/presidential-memorandum-hospital-visitation>). (Accessed on July 22, 2010.)

- Note information about the patient's support person in the medical record and communicate the selection to staff.

#### □ **Communicate information about unique patient needs to the care team.**

Any information about patient needs should be easily and readily accessible at all points of care and in all relevant ancillary departments to help staff provide the necessary services and arrangements to meet patient needs.

- Note all relevant data in the patient's medical record.

- Create a process to identify any patients with unique needs (for example, color code the patient's chart, add flags or stickers to the chart, or use patient armbands to denote different patient needs). Consider posting signs on doors or above the patient's bed or using the whiteboard in the patient's room, with the patient's permission, to communicate information to staff.
- Inform staff of patient needs at specific transfer points, including transports for procedures, tests, or transfers to different care units or services.

### **References:**

1. The Joint Commission: Facts About Speak Up Initiatives. Updated January 2010. Available at [http://www.jointcommission.org/GeneralPublic/Speak+Up/about\\_speakup.htm](http://www.jointcommission.org/GeneralPublic/Speak+Up/about_speakup.htm). (Accessed March 3, 2010.)
2. Partnership for Clear Health Communication: Ask Me 3: What Can Providers Do? Boston: National Patient Safety Foundation, 2009. Available at [http://www.npsf.org/askme3/PCHC/what\\_can\\_provid.php](http://www.npsf.org/askme3/PCHC/what_can_provid.php). (Accessed March 1, 2010.)
3. National Council on Disability: *The Current State of Health Care for People with Disabilities*. Washington, DC: National Council on Disability, 2009. Available at <http://www.ncd.gov/newsroom/publications/2009/pdf/HealthCare.pdf>. (Accessed March 1, 2010.)







## Chapter Four

# END-OF-LIFE CARE

End-of-life care includes supportive and palliative care provided during the final phase of life. Each patient experiences and interprets the dying process differently according to personal, cultural, religious, and spiritual beliefs, values, and preferences. Staff need to be aware of and elevate the role of the patient's surrogate decision-maker and family during end-of-life care. The hospital may need to adapt existing policies and procedures to ensure their participation during this final phase of life.

This chapter focuses on the importance of integrating effective communication, cultural competence, and patient- and family-centered care into the care delivery system at the end of life. Addressing the patient's communication needs is essential, and in some cases, the hospital may need to meet the communication needs of the patient's surrogate decision-maker or family members to involve them in care planning and discussions.

The next section includes both recommended issues to address at the end of life (with check boxes) and practice examples (with round bullets). While the recommended issues present broad, overarching concepts that all hospitals should address, the example practices and methods may not apply to all hospital types, sizes, or settings.

### ✓ Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care During End-of-Life Care

- Address patient communication needs during end-of-life care.
- Monitor changes in the patient's communication status during end-of-life care.
- Involve the patient's surrogate decision-maker and family in end-of-life care.
- Address patient mobility needs during end-of-life care.
- Identify patient cultural, religious, or spiritual beliefs and practices at the end of life.
- Make sure the patient has access to his or her chosen support person.

### Recommended Issues and Related Practice Examples to Address During End-of-Life Care

- Address patient communication needs during end-of-life care.**

Communication assistance should be provided during end-of-life care to meet the patient's communication needs identified throughout the continuum of care. This information should be recorded in the patient's medical record so that any documented communication needs trigger staff to arrange for the appropriate communication assistance.\*

  - Check the patient's medical record for any identified communication needs, including the patient's preferred language and any sensory or communication impairments.
  - Arrange for language services to help with treatment of patients whose preferred language is not English or who are deaf.

\* See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 40 and 41) for additional information on providing language services, auxiliary aids, and augmentative and alternative communication resources.

- Make sure that appropriate auxiliary aids and services are available during treatment of patients who have sensory impairments.
- Provide augmentative and alternative communication (AAC) resources to help with treatment of patients with communication impairments.
- Note the use of communication assistance in the medical record and communicate needed aids and services to staff.
- Provide communication assistance to surrogate decision-makers whose preferred language is not English or have sensory or communication needs to involve the patient's surrogate decision-maker in care discussions.

#### □ Monitor changes in the patient's communication status during end-of-life care.

A change in health status or a result of medical treatment or procedures can impair the patient's ability to communicate. Patients may develop new or more severe communication impairments at the end of life, and staff should be aware of any changes in the patient's communication status.

- Determine if the patient has developed new or more severe communication impairments during end-of-life care and contact the Speech Language Pathology Department, if available. Provide AAC resources, as needed, to help during treatment.
- Anticipate the communication needs of the patient who is expected to develop communication impairments from scheduled treatment or procedures during end-of-life care (for example, as a result of intubation, tracheostomy, sedation, or other interventions that may compromise the patient's ability to communicate).
- Note any changes in the patient's communication status in the medical record and communicate new needs to staff.

#### □ Involve the patient's surrogate decision-maker and family in end-of-life care.

Both the surrogate decision-maker and the patient's family must be involved (per the patient's wishes) to tailor end-of-life care to the patient's unique needs. Staff should make sure that the patient's surrogate decision-maker and family have an opportunity to ask questions and provide opportunities for them to participate in care discussions.

- Remind the patient of his or her right to designate a surrogate decision-maker.\* If the patient does not have a surrogate decision-maker, encourage the patient to identify such an individual during end-of-life care.
- Ask the patient which, if any, family members he or she would like to involve in end-of-life care. Family members may be broadly defined to include friends and same-sex partners.†
- Many cultural groups prefer that the patient's family, in addition to or rather than the patient, participate in decision making. This situation may seem to contradict an emphasis on patient autonomy and consent; however, staff need to respect the patient's desire to use a surrogate decision-maker even if the patient is competent. In such instances, staff should note that the patient has deferred decision-making for cultural reasons and identify the surrogate decision-maker in the medical record.
- Educate the patient and surrogate decision-maker and family regarding the dying process.
- Allow family to participate in end-of-life care by providing comfort during the dying process by touching, talking, playing favorite music, or participating in care activities such as washing.
- Adapt existing hospital procedures to better involve the surrogate decision-maker and family in care discussions. For example, consider rescheduling patient rounds or making sure the information provided during rounds is available to the patient's surrogate decision-maker and family members at a later time.
- Provide communication assistance to surrogate

\* See Chapter 1: Admission (page 10) for additional information on the patient's right to designate a surrogate decision-maker.

† Family involvement is a critical issue for lesbian, gay, bisexual, and transgender (LGBT) patients and families. In some cases, biological family members may disapprove of the patient's same-sex relationship and may try to exclude the patient's partner from visitation or decision making. Exclusion of a primary caregiver may compromise treatment. When treating children with same-sex parents, staff should include both parents in discussions about the child's health care, even if both do not have legal custody. See the April 15, 2010 presidential memorandum respecting the rights of hospital patients to receive visitors and to designate surrogate decision-makers for medical emergencies regardless of their status of legally recognized immediate family members at <http://www.whitehouse.gov/the-press-office/presidential-memorandum-hospital-visitation>.

decision-makers and family members whose preferred language is not English or who have sensory or communication impairments to facilitate involvement in end-of-life care.\*

- Make sure that appropriate communication supports are in place during care discussions; staff should not rely on the patient's family or friends to interpret.
- Notify the surrogate decision-maker and family of ongoing opportunities to ask questions. Encourage the surrogate decision-maker and family to write down questions for discussion with the care team.

#### ❑ Address patient mobility needs during end-of-life care.

Patients receiving end-of-life care may develop new or additional mobility needs. The patient also may be at an increased risk for falls.

- Assess whether the patient needs mobility assistance, including the type of and circumstances in which assistance is required.
- Determine whether the patient requires accommodations (such as adaptive switches or an intercom call system) to access the nurse call system.
- Make sure appropriate precautions are in place to prevent falls. Some hospitals post a sign above the patient's bed or door or use special colored socks or bracelets to identify a patient at risk for falls.
- Note the need for mobility assistance in the medical record and communicate these needs to staff.

#### ❑ Identify patient cultural, religious, or spiritual beliefs and practices at the end of life.

Cultural, religious, or spiritual beliefs can affect the patient's or his or her family's perception of illness and how they approach death and dying. End-of-life situations often trigger distress and reduce the patient's ability to cope, communicate, and participate in care decisions.

- Ask the patient if there are any cultural, religious, or spiritual beliefs or practices that may ease his or her care at the end of life.
- Consult a professional chaplain, whenever possible, when staff identify a patient entering the end-of-life phase of care. The chaplain can complete a spiritual assessment and may have screening questions to



#### Helpful Tip: Cultural, Religious, and Spiritual Considerations at the End of Life

Each patient has unique beliefs and preferences, and several cultural, religious, and spiritual considerations may arise during end-of-life care. Staff should respect the patient's needs and approach the following issues with sensitivity:

- Openly discussing death and dying
- Completing advance directives
- Acknowledging the end of life
- Discussing organ and tissue donation
- Performing rituals prior to and after death
- Positioning or touching the patient as death approaches
- Identifying the individuals the patient wants to be present during the dying process and at death, including family members, friends, religious leaders, and cultural leaders
- Removing and disposing of tubes and needles
- Using sedation
- Washing of the body
- Moving the body after death
- Allowing individuals to remain with or near the body after death

identify religious practices, relaxation techniques, and other coping resources.

- Make sure that staff are aware of any garments, religious items, or rituals important to the patient during end-of-life care.
- Provide an area or space to accommodate the patient's and family's need to pray. In addition, ask the patient and family if there are specific times of day to avoid scheduling tests or procedures in order to respect religious or spiritual practices.
- Note any cultural, religious, or spiritual needs at the end of life in the medical record and communicate these preferences to staff.

#### ❑ Make sure the patient has access to his or her chosen support person.

The patient should have an opportunity to identify an individual to provide emotional support, give comfort, and alleviate fear at the end of life. A patient that did not

\* See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 40 and 41) for additional information on providing language services, auxiliary aids, and augmentative and alternative communication resources.

choose a support person earlier may choose to do so during end-of-life care.

- Explain the purpose of the patient's support person, including limitations if the presence of the support person infringes on others' rights, compromises safety, or is medically or therapeutically contraindicated.
- Make staff aware the patient has chosen a support person to be present during end-of-life care.
- Allow the patient access to the support person at all times.\*
- Ask if the patient would like to involve the chosen support person during rounds, patient education, and

other crucial decision-making and care processes. The support person may or may not be the patient's designated surrogate decision-maker.

- Note information about the patient's support person in the medical record and communicate the selection to staff.

---

\* On April 15, 2010, President Obama released a presidential memorandum for the secretary of the Department of Health and Human Services respecting the rights of hospital patients to receive visitors and to designate surrogate decision-makers for medical emergencies regardless of their status of legally recognized immediate family members (available at <http://www.whitehouse.gov/the-press-office/presidential-memorandum-hospital-visitation>). (Accessed on July 22, 2010.)



## Chapter Five

# DISCHARGE AND TRANSFER

The hospital should incorporate the patient's unique needs into discharge planning and instruction. When the hospital plans to transfer the patient to another facility (for example, nursing home, hospice, rehabilitation center) or give the patient a referral for follow-up care and treatment with another provider, it must identify providers that can meet the patient's needs. Hospitals should also consider developing a system to help patients that may need further instruction after discharge.

Patients and their families may be overwhelmed by the complex health care information included in the discharge process. To fully engage the patient in discharge planning and instruction, the hospital must address the patient's communication needs and provide discharge instructions that meet those unique needs. This should also support the patient's ability to understand and act on health information.

The next section includes both recommended issues to address during the patient discharge or transfer process (with check boxes) and practice examples (with round bullets). While the recommended issues present broad, overarching concepts that all hospitals should address, the example practices and methods may not apply to all hospital types, sizes, or settings.

### ✓ Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care During Discharge and Transfer

- Address patient communication needs during discharge and transfer.
- Engage patients and families in discharge and transfer planning and instruction.
- Provide discharge instruction that meets patient needs.
- Identify follow-up providers that can meet unique patient needs.

### Recommended Issues and Related Practice Examples to Address During Discharge and Transfer

- Address patient communication needs during discharge and transfer.

Communication assistance should be provided during discharge and transfer to meet the communication needs previously identified during the course of care. Record this information in the patient's medical record so that any documented communication needs trigger staff to arrange for the appropriate communication assistance.\*

- Check the patient's medical record to determine if any communication needs, including the patient's preferred language and any sensory or communication impairments, were previously identified.
- Arrange for language services to facilitate communication during discharge and transfer planning and instruction for patients whose preferred language is not English or who are deaf.
- Make sure that appropriate auxiliary aids and services are available during discharge and transfer planning and instruction for patients that have communication or sensory needs.

\* See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 40 and 41) for additional information on providing language services, auxiliary aids, and augmentative and alternative communication resources.

- Provide augmentative and alternative communication (AAC) resources to help with communication during discharge or transfer planning and instruction for patients with communication needs.
- Note the use of communication assistance in the medical record and communicate needed aids and services to staff.

### □ Engage patients and families in discharge and transfer planning and instruction.

Staff must involve both the patient and his or her family to tailor discharge and transfer planning and instruction to the patient's unique needs. Staff should encourage the patient and family to ask questions and participate in discussions regarding discharge and transitions in care.

- Ask the patient which, if any, family members he or she would like to involve in discharge or transfer planning and instruction. Family members may be broadly defined to include friends and same-sex partners.\* Staff should discuss a child's care with both parents when possible, including co-custodial parents and same-sex parents, even if both do not have legal custody.
- Ask the patient if he or she has a primary caregiver at home. Staff should make sure to involve the primary caregiver identified by the patient in discharge planning and instruction.
- Consider providing communication assistance to family members whose preferred language is not English or who have sensory or communication needs to facilitate family involvement in planning for transitions in care.†
- Make sure that appropriate communication supports are in place during care discussions; staff should not rely on the patient's family or friends to interpret.
- Notify the patient and family of ongoing opportunities to ask questions. Encourage the patient and family to write down questions for discussion with staff who plan transitions in care.

### □ Provide discharge instruction that meets patient needs.

The hospital should modify discharge instructions and materials to help the patient understand and act on health information.

- Ask the patient how he or she prefers to receive information (for example, by reading, hearing, or viewing).
- Speak in plain language instead of using technical terminology or medical jargon. Include examples and stories whenever possible.
- Use visual models, diagrams, or pictures to illustrate discharge instructions.
- Help the patient gather basic health information by using methods such as AskMe3™, a strategy for asking and answering three questions about the patient's care [1].
- Use the "teach back" method to assess understanding. This involves asking the patient to explain in his or her own words the information that the staff shared, or asking the patient to demonstrate a skill that was taught.
- Refrain from simply asking the patient "Do you understand?" to evaluate understanding. Regardless of their ability to understand the information, many people who do not understand may still answer, "Yes."
- Use discharge instructions that meet health literacy needs. Materials should be written at a 5th grade or lower reading level. Consider revising written materials to address the health literacy needs of all patients. Use readability tests, divide complex information into bullet points, and modify document font, layout, and design to revise written materials to improve readability.‡
- Use discharge instruction materials that have been translated into the hospital's most frequently encountered languages whenever possible. Even if the hospital provides translated materials, it is still necessary to provide an interpreter for the patient's preferred language during discharge instruction discussions.

\* Family involvement is a critical issue for lesbian, gay, bisexual, and transgender patients and their families. In some cases, biological family members may disapprove of the patient's same-sex relationship and may try to exclude the patient's partner from visitation or decision making. Exclusion of a primary caregiver may compromise adherence with treatment recommendations. When treating children with same-sex parents, staff should include both parents in discussions about the child's health care, even if both do not have legal custody.

† See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 40 and 41) for additional information on providing language services, auxiliary aids, and augmentative and alternative communication (AAC) resources.

‡ See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 42) for additional information on integrating health literacy strategies into patient discussions and materials.

- Ask the patient if he or she would benefit from a follow-up phone call, if possible, to review discharge instructions and ask additional questions.
- Provide appropriate hospital phone numbers to the patient or family and encourage them to call with any questions they may have post-discharge.

#### □ Identify follow-up providers that can meet unique patient needs.

When the hospital transfers the patient to another care facilities (for example, nursing home, hospice, rehabilitation center), staff should notify the facility of the patient's unique needs to make sure that the receiving organization can arrange for appropriate services and accommodations. Share information about the patient's communication, cultural, religious or spiritual, mobility, or other needs to aid in the transition of care and ease the adjustment to a new facility.

- Create a list of follow-up providers that offer the appropriate services and accommodations to meet the patient's communication, cultural, religious or spiritual, mobility, or other needs.
- Identify health care providers that are sensitive to the concerns of lesbian, gay, bisexual, and transgender

(LGBT) patients and families. The Gay and Lesbian Medical Association maintains an online directory of LGBT-friendly providers available at <http://www.glma.org>.

- Refer any patient who requires follow-up care to a provider (for example, home health organization, community clinic, primary care provider, medical home). Staff should arrange a meeting between the patient and the follow-up care provider prior to discharge, whenever possible.
- Identify social services available in the community, and refer the patient when necessary. Provide the patient with social service agency brochures outlining available services, whenever possible.
- Make sure that follow-up providers for patients that require mobility assistance have the specialized equipment necessary to perform examinations and tests. For example, the hospital should make sure that a recommended physical therapy provider has the appropriate equipment to address the patient's mobility needs.

## Reference:

1. Partnership for Clear Health Communication: Ask Me 3: What Can Providers Do? Boston: National Patient Safety Foundation, 2009. Available at [http://www.npsf.org/askme3/PCHC/what\\_can\\_provid.php](http://www.npsf.org/askme3/PCHC/what_can_provid.php). (Accessed March 1, 2010.)







## Chapter Six

# ORGANIZATION READINESS

A hospital's ability to advance effective communication, cultural competence, and patient- and family-centered care in hospitals rests on its state of organization readiness. To create the domains of organization readiness for the *Roadmap for Hospitals*, staff incorporated elements from the following frameworks:

- The Joint Commission's *Hospitals, Language, and Culture* framework [1]
- American Medical Association's *Ethical Force Program: Improving Communication—Improving Care* [2]
- National Quality Forum's *Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency* [3]
- The National Research Corporation (NRC) Picker's eight dimensions of patient-centered care [4]
- The Commonwealth Fund's attributes of patient-centered primary care practices [5]
- Planetree's acute-care components of the Planetree Model [6]

This chapter explores five domains for organization readiness: leadership; data collection and use; workforce; provision of care, treatment, and services; and patient, family, and community engagement (see Table 6-1, page 35). Each domain represents a key area that hospitals should address to make sure necessary systems and processes exist to meet the unique needs of each patient. The hospital can use the domains as a framework for exploring the organization's readiness to address patient needs throughout the care continuum.

The next sections include both recommended issues to address during organization readiness (with check boxes) and practice examples (with round bullets) for the five domains of organization readiness. While the recommended issues present broad, overarching concepts that all hospitals should

## ✓ Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care Through Organization Readiness

### **Leadership**

- Demonstrate leadership commitment to effective communication, cultural competence, and patient- and family-centered care.
- Integrate unique patient needs into new or existing hospital policies.

### **Data Collection and Use**

- Conduct a baseline assessment of the hospital's efforts to meet unique patient needs.
- Use available population-level demographic data to help determine the needs of the surrounding community.
- Develop a system to collect patient-level race and ethnicity information.
- Develop a system to collect patient language information.
- Make sure the hospital has a process to collect additional patient-level information.

### **Workforce**

- Target recruitment efforts to increase the pool of diverse and bilingual candidates.
- Ensure the competency of individuals providing language services.
- Incorporate the issues of effective communication, cultural competence, and patient- and family-centered care into new or existing staff training curricula.
- Identify staff concerns or suggested improvements for providing care that meets unique patient needs.

(continued on page 34)

## ✓ Checklist for Organization Readiness (continued)

### Provision of Care, Treatment, and Services

- Create an environment that is inclusive of all patients.
- Develop a system to provide language services.
- Address the communication needs of patients with sensory or communication impairments.**
- Integrate health literacy strategies into patient discussions and materials.
- Incorporate cultural competence and patient- and family-centered care concepts into care delivery.

### Patient, Family, and Community Engagement

- Collect feedback from patients, families, and the surrounding community.
- Share information with the community about the hospital's efforts to meet unique patient needs.

address, the example practices and methods may not apply to all hospital types, sizes, or settings.

## Recommended Issues and Related Practice Examples to Address the Leadership Domain of Organization Readiness

### Demonstrate leadership commitment to effective communication, cultural competence, and patient- and family-centered care.

The buy-in and support from hospital leaders make it easier to allocate resources and provide services necessary to meet patient communication, cultural, religious, spiritual, mobility, or other needs.

- Involve staff at all organization levels in decision making.
- Encourage leaders to participate in interdisciplinary patient rounds.
- Communicate leadership commitment to effective communication, cultural competence, and patient- and family-centered care during new staff orientation.
- Create opportunities for leaders to engage staff on a regular and ongoing basis (for example, establish “office hours” with executives or breakfast with the President [6]).
- Identify an individual(s) directly accountable to leadership for overseeing hospital efforts to advance effective communication, cultural competence, and patient- and family-centered care.
- Incorporate community benefit reporting into the design and implementation of services that address barriers to care (as required of non-profit hospitals by the Internal Revenue Service [7]).
- Integrate the Office of Minority Health's *National Standards for Culturally and Linguistically Appropriate Services* (known as the CLAS standards) into the hospital's services, programs, and initiatives [8].

### Integrate unique patient needs into new or existing hospital policies.

Hospitals should develop new or modify existing policies and procedures to incorporate the concepts of effective communication, cultural competence, and patient- and family-centered care.

- Incorporate information about providing communication assistance to patients whose preferred language is not English or who have sensory or communication impairments into applicable hospital policies and procedures.\*
- Define *family* to explicitly include any individual that plays a significant role in the patient's life such as spouses, domestic partners, significant others (of both different-sex and same-sex), and other individuals not legally related to the patient. Use this expanded definition in all hospital policies, including those addressing visitation, access to chosen support person, identification of surrogate decision-makers and advance directives.†

\* See the Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 40 and 41) for additional information on providing language services and communication assistance.

† On April 15, 2010, President Obama released a presidential memorandum for the secretary of the Department of Health and Human Services respecting the rights of hospital patients to receive visitors and to designate surrogate decision-makers for medical emergencies regardless of their status of legally recognized immediate family members (available at <http://www.whitehouse.gov/the-press-office/presidential-memorandum-hospital-visitation>). (Accessed on July 22, 2010.)

**Table 6-1. Five Domains of Organization Readiness for Implementing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care**

- 1. Leadership.** Leaders must clearly articulate a hospital's commitment to meet the unique needs of its patients to establish an organization culture that values effective communication, cultural competence, and patient- and family-centered care.
- 2. Data Collection and Use.** The hospital must define what types of data to collect, how to collect data, and how to use data for service planning and resource allocation to advance effective communication, cultural competence, and patient- and family-centered care.
- 3. Workforce.** The hospital and its staff, including the medical staff, must commit to meeting the unique needs of the patients they serve.
- 4. Provision of Care, Treatment, and Services.** The hospital, in striving to meet the individual needs of each patient, must embed the concepts of effective communication, cultural competence, and patient- and family-centered care into the core activities of its care delivery system.
- 5. Patient, Family, and Community Engagement.** The hospital must be prepared to respond to the changing needs and demographics of the patients, families, and the community served. The hospital can identify the need for new or modified services by being involved and engaged with patients, families, and the community.

- Maintain the confidentiality of sensitive patient information, including race, ethnicity, disability, sexual orientation, and gender identity or expression information.
- Protect patients from discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
- Allow patients open access to their medical records to review their health care information and encourage patients and families to participate in care discussions.

### **Recommended Issues and Related Practice Examples that Address the Data Collection and Use Domain of Organization Readiness**

#### **□ Conduct a baseline assessment of the hospital's efforts to meet unique patient needs.**

Organization assessments and other assessments (such as patient satisfaction surveys, data on readmissions, and so on) can and should be used to develop and monitor the effects of focused quality improvement activities that support effective communication, cultural competence, and patient- and family-centered care. It is important for hospitals to conduct an organization assessment that

measures baseline performance on specific issues to know where improvement might be necessary, detect gaps and areas of excellence, and tailor improvement interventions.

An organization assessment can include standardized tools that allow for valid cross-organizational comparisons, benchmarking, and objective performance tracking over time. Assessments may comprise informal discussions, organization or individual self assessments, or standardized evaluations.

Some helpful examples of organization assessment tools and resources include the Joint Commission's "Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool" [9], the 360-degree organizational communication climate assessment toolkit from The Ethical Force Program® (led by the Institute for Ethics at the American Medical Association) [2,10,11], Planetree's "Self-Assessment Tool" in its *Patient-Centered Care Improvement Guide* [12], *Conducting a Cultural Competence Self-Assessment* [13], *The Americans with Disabilities Act Checklist for Readily Achievable Barrier Removal* [14], or information included in the *Human Rights Campaign Foundation's Healthcare Equality Index* [15].

- Identify existing hospital policies and procedures that support effective communication, cultural competence, and patient- and family-centered care.
- Collect feedback from all key stakeholder groups.

- Identify service gaps, as well as areas of good or excellent performance, and generate ideas to better meet patient needs.

### □ Use available population-level demographic data to help determine the needs of the surrounding community.

An awareness of the demographic composition of the community allows hospitals to plan for the services necessary to meet patient needs. Hospitals can use population-level data from several available sources to identify and respond to changes in the demographics of the surrounding community.\*

- Use demographic data to determine whether new services or programs should be developed to address the needs of the community. Population-level demographic data on race, ethnicity, language, and disability may be obtained from U.S. Census Bureau figures, local school enrollment profiles, voter registration records, and public health department databases. Data from the previous 3 to 5 years will best represent current needs in the community.
- Consider information on national and state literacy and health literacy levels, available from the 2003 National Assessment of Adult Literacy Survey [16], when developing admission or other forms, patient education materials, or discharge instruction.†
- Use national- and state-level data on sexual orientation from Web sites such as <http://www.census.org> and <http://www.gaydata.org> to develop initiatives that address the health concerns of lesbian, gay, bisexual, or transgender (LGBT) patients.
- Consider using indirect data analysis methods such as geocoding (that is, matching addresses to community needs) and surname analysis to plan services and target community-based interventions [3].
- Conduct focus groups or interview community leaders to identify changes in the demographics and needs of the surrounding community.

### □ Develop a system to collect patient-level race and ethnicity information.

Understanding the racial and ethnic characteristics of the patient population can help hospitals identify potential

disparities in care and plan for services that meet unique patient needs.

- Modify paper or electronic medical records to allow for the collection of patient race and ethnicity information. This may involve adding new fill-in spaces, fields, or drop-down menus to the forms to capture race and ethnicity data elements.
- Use standardized racial and ethnic categories to collect race and ethnicity information. The Institute of Medicine (IOM) recommends hospitals choose from among the standardized categories developed by the Office of Management and Budget (OMB) shown in Table 6-2, page 37, to collect hispanic ethnicity and race data. The IOM also suggests that hospitals use granular ethnicity categories applicable to the population served when collecting such information. Given variations in locally relevant populations, no single national set of additional ethnicity categories is best for all entities that collect these data. Refer to the Institute of Medicine report *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* for guidance on collecting race and ethnicity information, recommended categories to use, and other helpful resources [17].
- Address the collection of patient-level race and ethnicity information in hospital policies and procedures.
- Train staff to collect patient-level race and ethnicity information. Consult the *Health Research and Educational Trust Disparities Toolkit* for information and resources on staff training [18].
- Use aggregated patient-level race and ethnicity data to develop or modify services, programs, or initiatives to meet service population needs.

### □ Develop a system to collect patient language information.

The collection of patient language information allows hospitals to identify the language needs of their patient population and provide appropriate language services to meet those needs.

- Modify paper or electronic medical records to allow for the collection of patient language information. This may involve adding new fill-in spaces, fields, or drop-down menus to the forms to capture language data.

\* For some hospitals, the surrounding community may not correspond to the service population (for example, Veteran's Administration [VA] hospitals, children's hospitals).

† See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 42) for additional information on integrating health literacy strategies into patient discussions and materials.

**Table 6-2. Categorization of Patient-Level Race and Ethnicity Data**

**Categories to Capture Hispanic Ethnicity Data**

- Hispanic or Latino
- Not Hispanic or Latino

**Categories to Capture Race Data** (select one or more)

- Black or African American
- White
- Asian
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Some other race

**Categories to Capture Granular Ethnicity**

- Locally relevant choices from a standardized national set
- “Other, please specify: \_\_\_\_\_”
- Roll-up to the OMB\* categories

\* OMB, Office of Management and Budget

**Source:** Adapted from Table 3-1. OMB Race and Hispanic Ethnicity Categories According to a One- and Two-Question Format in Ulmer C., McFadden B., Nerenz D.: *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: The National Academies Press, 2009.

- Use standardized language categories to collect patient language information (see Table 6-3, page 38). Refer to the Institute of Medicine report *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* for guidance on collecting patient language information, recommended categories to use, and helpful resources [17].
- Address the collection of patient-level language information in hospital policies and procedures.
- Train staff to collect patient-level language information. Consult the *Health Research and Educational Trust Disparities Toolkit* for information and resources on training staff to collect patient language data [18].

- Use aggregated patient-level language data to develop or modify services, programs, or initiatives to meet service population needs.

**□ Make sure the hospital has a process to collect additional patient-level information.**

Hospitals should consider collecting additional patient-level cultural, religious, spiritual, mobility, or other information, depending on the patient population. The hospital can use this information to plan for services, accommodations, or specialized equipment to meet unique patient needs.

- Consider adding optional data fields to medical records, admission materials, and assessment forms to allow flexible data collection of additional patient-level information as needed. For example, create data fields that allow staff to collect information on the patient’s religion, mobility needs, sexual orientation, gender identity, or gender expression when considered necessary.\*
- Use inclusive language to collect patient information. For example, rather than asking the patient “are you married,” consider asking “are you in a relationship” or “do you have a partner or significant other.” In addition, consider including “partnered” as an option on forms that ask “single, married, divorced.”
- Use aggregated patient-level data to develop or modify services, programs, or initiatives.

**Recommended Issues and Related Practice Examples that Address the Workforce Domain of Organization Readiness**

**□ Target recruitment efforts to increase the pool of diverse and bilingual candidates.**

Creating a diverse workforce that reflects the patient population can increase ethnic and language concordance between staff and patients, which may improve communication and patient engagement. Include equal opportunity employment statements in job announcements.

- Advertise job openings in targeted foreign-language publications and other media, for example, in Spanish-language magazines or local television broadcasts.
- Define policies that accommodate the dress, hair styles, and daily religious practices of the local workforce whenever possible.

\* See Appendix E: Resource Guide (page 79) for resources on collecting patient-level data, which include suggested data fields to capture this information.

**Table 6-3. Categorization of Patient-Level Language Data****Categories of English Proficiency\***

- Very well
- Well
- Not well
- Not at all

**Preferred Spoken Language for Health Care**

- Locally relevant choices from standardized national set
- “Other, please specify: \_\_\_\_\_”
- Sign language

**Preferred Written Language**

- Locally relevant choices from standardized national set
- Braille

\* The Institute of Medicine recommends hospitals collect information on an individual’s assessment of his or her proficiency with English and the patient’s preferred spoken and written language for health care discussions and education. Limited English proficiency is defined as anything less than “very well”.

**Source:** Adapted from Table 4-1. Summary of Question Types and Categories in Ulmer C., McFadden B., Nerenz D.: *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: The National Academies Press, 2009.

- Support training and career development activities to help culturally and linguistically diverse nonclinical staff advance to a patient care position.
- Develop relationships with local community colleges that offer health care career training to develop volunteer, work-study, and internship programs.
- Encourage the transition of English as a second language (ESL) students into health care careers by partnering with community-based organizations that offer ESL courses, such as technical colleges, community colleges, adult literacy programs, or workforce development programs.

### □ Ensure the competency of individuals providing language services.

Language services that meet patient communication needs promote quality and safety. Hospitals must ensure the competency of their language interpreters and translators.\*

- Define qualifications for language interpreters and translators to comprise a combination of language proficiency assessment, education, training, and experience.
- Consider including certification by the Registry of Interpreters for the Deaf or the National Association of the Deaf as a qualification for sign language interpreters.†
- Conduct an assessment of language proficiency in both English and the target language for language interpreters and translators, or contact an external vendor to perform language proficiency assessments for these individuals.
- Promote ongoing training and educational opportunities for language interpreters and translators.
- Find out the qualifications of the language interpreters and translators provided by an external vendor for contracted language services.
- Refrain from relying on untrained individuals, including a patient’s family members or friends, to provide language services.
- Consult resources from the National Council on Interpreting in Health Care (<http://www.ncihc.org>) and the American Translators Association (<http://www.atanet.org>) for additional guidance on the qualifications and competencies to expect of language interpreters and translators.‡

### □ Incorporate the issues of effective communication, cultural competence, and patient- and family-centered care into new or existing staff training curricula.

Staff training should provide information and guidance about the hospital’s efforts to address unique patient cultural, religious, spiritual, mobility, or other needs. Address with staff all relevant policies, services, and programs for effective communication, cultural competence, and patient- and family-centered care.

\* See Chapter 6: Organization Readiness: Provision of Care, Treatment, and Services (page 40) for additional information on developing a system to provide language services.

† See Appendix E: Resource Guide (page 82) for further information on interpreter qualifications.

‡ See Appendix E: Resource Guide (page 82) for additional resources on training and qualifications for language interpreters and translators.

- Consider varying the methods used to provide staff training, including in-service sessions, grand rounds, case studies, DVD courses, and online modules.\*
- Provide staff training opportunities at intervals throughout the year (for example, new staff orientation, ongoing training).
- Incorporate staff training into yearly performance expectations.
- Support the hospital's current efforts to address effective communication, cultural competence, and patient- and family-centered care. For example, train staff to address patient communication needs, including patients whose preferred language is not English or patients who have sensory or communication impairments.
- Encourage staff to improve their overall communication skills, including communication between patients and providers and communication between providers.
- Address unique patient needs in relevant policies and procedures (for example, visitation, access to chosen support person, nondiscrimination).
- Inform staff about federal and state laws and regulations that support effective communication, cultural competence, and patient- and family-centered care.†

#### **□ Identify staff concerns or suggested improvements for providing care that meets unique patient needs.**

The hospital relies on its staff to communicate effectively and provide culturally competent, patient- and family-centered care. Staff should have the opportunity to voice any concerns with or suggest improvements to meet unique patient cultural, religious, spiritual, mobility, or other needs.

- Conduct a staff survey to evaluate the staff's current ability to meet patient needs, including their experiences using language services and auxiliary aids, barriers to accommodating cultural and religious or spiritual needs, and any other issues that should be addressed.
- Create an environment that welcomes diverse staff members which, in turn, welcomes diverse patients. Provide support for staff caucuses or special interest groups to freely and openly discuss any cultural, religious, disability, LGBT, or other concerns.

- Promote staff discussion around the challenges and barriers to providing care that meets unique patient needs. For example, consider implementing Schwartz Center Rounds®, which provides multidisciplinary providers an opportunity to discuss difficult emotional and social issues that arise while caring for patients [19].
- Protect staff from discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression.

### **Recommended Issues and Related Practice Examples that Address the Provision of Care, Treatment, and Services Domain of Organization Readiness**

#### **□ Create an environment that is inclusive of all patients.**

It is important for the physical hospital environment to support the diversity of the patient population. From the layout of the waiting areas to accessible equipment to the navigational signage to artwork and magazine selection, hospitals can create a welcoming atmosphere to put patients at ease.

- Incorporate the concepts and principles of universal design to create a physical environment inclusive of all patients. The hospital can use the universal design philosophy when building or remodeling hospital spaces or purchasing medical equipment to make sure facilities, products, and services can be used and accessed by all people. Table 6-4, on page 40, outlines the seven principles of universal design [20].
- Provide a diverse collection of magazines and brochures in the waiting area inclusive of the preferences of all patients. The hospital should consider from among the many publications tailored to different populations, cultures, and communities when selecting materials to match their patient population.
- Reflect the diversity of the patient population in hospital marketing materials and decor.
- Make sure navigational signage can be understood by the patient population. Incorporate pictures or symbols into navigational signage, or consider providing bilingual signage.

\* See Appendix E: Resource Guide (pages 80 and 81) for further information on staff training resources and courses.

† See Appendix D: Laws and Regulations (page 65) for additional information on laws and regulations.

**Table 6-4. The Seven Principles of Universal Design**

1. **Equitable Use.** The design is useful and marketable to people with diverse abilities.
2. **Flexibility in Use.** The design accommodates a wide range of individual preferences and abilities.
3. **Simple and Intuitive Use.** Use of the design is easy to understand, regardless of the user's experience, knowledge, language skills, or current concentration level.
4. **Perceptible Information.** The design communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities.
5. **Tolerance for Error.** The design minimizes hazards and the adverse consequences of accidental or unintended actions.
6. **Low Physical Effort.** The design can be used efficiently and comfortably and with a minimum of fatigue.
7. **Size and Space for Approach and Use.** Appropriate size and space is provided for approach, reach, manipulation, and use regardless of the user's body size, posture, or mobility.

**Source:** The Center for Universal Design: *The Principles of Universal Design*, Version 2.0. Raleigh, NC: North Carolina State University, 1997. Available at: [http://www.design.ncsu.edu/cud/about\\_ud/udprinciples.htmlformat.html#top](http://www.design.ncsu.edu/cud/about_ud/udprinciples.htmlformat.html#top). (Accessed on March 2, 2010.)

- Designate an area of the hospital for patients and their families to pray or observe religious services.

#### □ **Develop a system to provide language services.**

The provision of safe, quality care requires effective patient-provider communication. Hospitals must develop a system to provide language services to address the communication needs of patients whose preferred language is not English, including patients who communicate through sign language.

- Establish a centralized budget to provide language services throughout the hospital.



#### **Helpful Tip: Determine Which Written Materials to Translate**

Written information can be difficult to classify as “vital” or “nonvital.” Additionally, some documents contain both vital and nonvital information. Consider whether the written materials have a clinical, legal, or other important consequence to help determine which documents need to be translated.

**Source:** Office for Civil Rights: *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*. Washington, DC: U.S. Department of Health and Human Services Office for Civil Rights, 2003. Available at <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidance/document.html>. (Accessed March 2, 2010.)

- Determine the types of language services the hospital provides or needs to provide, including bilingual care providers, language interpreters, and translators either on staff or provided by an external vendor for contracted language services.
- Identify the methods used to provide language services (for example, in-person, telephone, or video remote interpreting).
- Consider the number of frequently encountered languages and languages less commonly encountered when determining the composition of language services.
- Offer a mixture of language services based on the needs of the patient population so that services are available 24 hours a day, 7 days a week.
- Provide translated written documents for frequently encountered languages to meet patient communication needs. Determine which documents and languages need to be translated to meet the needs of the patient population. Table 6-5, on page 41, presents a list of vital and nonvital documents hospitals may consider when determining which documents to translate.
- Consider developing pre-recorded sign language video content for commonly used patient education materials to meet the needs of deaf patients.
- Incorporate language services information, such as types of services and qualifications for language



**Table 6-5. Identifying Vital Documents Appropriate for Translation****Vital Documents**

- Informed consent documents
- Complaint forms
- Information about free language assistance programs or services
- Notices of eligibility criteria for, rights in, denial or loss of, or decreases in benefits or services
- Intake forms that may have clinical consequences

**Non-Vital Documents**

- Menus
- Third-party documents, forms, or pamphlets distributed as a public service
- Large documents such as enrollment handbooks (although vital information contained within these documents may need to be translated)
- General information intended for informational purposes only.

**Source:** Adapted from United States Department of Health and Human Services, Office for Civil Rights. *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons*. Washington, DC; 2003. Available at: <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>. (Accessed March 2, 2010.)

interpreters and translators, into new or existing hospital policies and procedures.

- Train staff on how to access language services and effectively work with interpreters.\*
- Inform patients of their right to receive language services.
- Note the use of language services in the patient's medical record.
- Monitor the use of language services.

□ **Address the communication needs of patients with sensory or communication impairments.**

Although patients with pre-existing hearing, visual, or speech impairments may arrive at the hospital with their own communication aids or devices, the hospital may need to provide auxiliary aids and services to facilitate communication with patients who experience a sensory or communication impairment due to their current medical condition.†

- Develop a system to provide auxiliary aids and services to address the communication needs of patients with sensory impairments. Such a system may include sign language interpreters, telecommunication device for the deaf (TDD) in public areas, volume control and hearing aid adaptable telephones, portable telephones that can be utilized in patient rooms, closed captioning services, and Braille materials. Select a mixture of services based on the patient population.

- Incorporate augmentative and alternative communication (AAC) resources into care delivery to address the needs of patients with communication impairments. Use a mixture of low, medium, and high tech resources to provide AAC services, including writing pads, pictorial or communication boards, visual pain scales, speech generating devices, and adaptive nurse call systems.
- Consider developing a communication kit that includes a combination of writing pads, hearing and vision devices, communication displays, or speech generating devices that is available at each nurses' station for patients with communication impairments.
- Identify the appropriate AAC resources to meet patient needs by incorporating referrals to communication impairment specialists, including speech-language pathologists and audiologists, into patient care.
- Offer a mixture of auxiliary aids and services and AAC resources 24 hours a day, 7 days a week.
- Incorporate information about auxiliary aids and services information and AAC resources into new or existing hospital policies and procedures.
- Train staff on how to access and work with auxiliary aids and services and AAC resources.
- Note the use of auxiliary aids and services and AAC resources in the patient's medical record.
- Monitor the use of auxiliary aids and services or AAC resources.

\* See Appendix E: Resource Guide (page 80) for more information on staff training resources and courses.

† See Appendix D: Laws and Regulations (page 68) for supporting information on the provision of auxiliary aids and services.

### □ Integrate health literacy strategies into patient discussions and materials.

The hospital should support the patient's ability to understand and act on health information. Health literacy strategies can be used to ensure patient comprehension and adapt materials to better meet patient needs.

- Ask a health literacy screening question of the patient, such as “Do you need help understanding health care information?”
- Ask the patient how he or she prefers to receive information (for example, by reading, hearing, or viewing it).
- Speak in plain language and avoid using technical terminology or medical jargon. Include examples and stories whenever possible.
- Help the patient gather basic health information by using a method such as AskMe3™, a strategy for asking and answering three questions about the patient's care [21].
- Use the “teach back” method to assess understanding by asking the patient to explain in his or her own words the information the staff shared or by asking the patient to demonstrate a skill that was taught.
- Refrain from simply asking the patient “Do you understand?” Regardless of their ability to understand the information, many people who do not understand may still answer “Yes.”
- Develop materials that meet health literacy needs. Material should be written at a 5th grade or lower reading level. Consider revising written materials to address the health literacy needs of all patients. Use readability tests, divide complex information into bullet points, and modify document font, layout, and design to improve readability.
- Develop non-written patient education options, such as audio files, pictograms, or video demonstrations.
- Pilot test patient materials with members of the patient population, surrounding community, or students from local adult literacy programs.

### □ Incorporate cultural competence and patient- and family-centered care concepts into care delivery.

Each patient has unique needs, beliefs, and preferences that can affect the way he or she views, receives, and participates in health care. Hospitals need to respect patient diversity and integrate the concepts of cultural

competence and patient- and family-centered care into the care delivery system.

- Encourage staff to develop a respectful partnership with each patient by asking open-ended questions, exploring cultural similarities and differences, and accommodating the patient's needs whenever possible. In addition, train staff to facilitate situations when the hospital cannot address certain needs or when an appropriate compromise cannot be determined.
- Use inclusive language to collect patient information. For example, when conducting a patient history, use neutral language when inquiring about sexual history. Encourage candidness among patients who indicate they are sexually active by routinely asking if their partners are “men, women, or both,” but do not require the patient to disclose this information [22].
- Train staff in the concept of cultural humility to develop self-awareness and a respectful attitude toward diverse points of view [23]. Do not expect staff to understand everything about every culture; instead encourage staff to engage patients and their families to gather information about individual needs, beliefs, and preferences that may influence care.
- Provide resources and tools to meet the cultural and religious needs of the most frequently encountered populations. For example, if the hospital serves a large Orthodox Jewish population, make staff aware of the dietary needs, customs, and religious practices that may affect care in this population.
- Create a patient resource center to provide materials and information on common health concerns, hospital services and programs, and community resources. Provide these materials in the hospital's most frequently encountered languages and in a manner that meets health literacy needs of the population.
- Provide mobility assistance and specialized equipment for patients with physical disabilities. Patient should be assigned to rooms that can accommodate his or her mobility needs, and any service animal, cane, or walker should be readily accessible to the patient.
- Train staff on the unique needs of dying patients and their families, including how to work with the organ procurement organization and how to address the needs of potential donor families.
- Include professional chaplains in care delivery whenever possible, as a valuable resource for cultural, religious, and spiritual information. Consult the chaplain when

addressing and accommodating patient's cultural, religious, and spiritual needs, beliefs, and practices [24].

## Recommended Issues and Related Practice Examples that Address the Patient, Family, and Community Engagement Domain of Organization Readiness

### □ Collect feedback from patients, families, and the surrounding community.

Hospitals should engage patients, families, and the surrounding community in discussions regarding existing hospital services and programs to determine whether existing hospital services meet unique patient needs.

- Make sure that the hospital complaint resolution system can accommodate feedback from patients and families with special communication needs. For example, hospitals should provide translated complaint forms for patients and families whose preferred language is not English. It may also be necessary to make sure that the complaint system is not reliant on written complaints since many patients may not feel comfortable putting information in writing.
- Conduct patient surveys in the relevant languages about the use of language services, auxiliary aids or services, or AAC resources to meet communication needs. Questions may address the patient's overall experience with the services, which services were used, and suggestions for improvement. Surveys may be conducted by phone or in person by a staff person since some patient populations are not likely to respond to written surveys.
- Ask patients and families about staff responsiveness to their cultural, religious, and spiritual needs during care planning and treatment, including whether and how those needs were accommodated.

- Invite patients and family members to share their experiences with the hospital through focus groups or advisory councils.
- Establish a community advisory board, comprised of a mixture of community members, stakeholders, and representatives of the major cultural and religious groups, that reports to leadership.
- Engage local adult literacy or adult basic education programs to provide feedback on written materials. These programs generally include culturally and economically diverse students, and represent all levels of literacy and educational experience.

### □ Share information with the surrounding community about the hospital's efforts to meet unique patient needs.

The hospital can demonstrate its commitment to effective communication, cultural competence, and patient- and family-centered care by sharing information with the community about the hospital's current services, programs, and initiatives to address their individual needs and issues.

- Engage the surrounding community through public hospital events and community health fairs.
- Publicize information about available services to meet unique patient needs through community- and faith-based organizations, targeted marketing strategies, and cultural media outlets.
- Post information about available services, programs, and initiatives to meet unique patient needs on the hospital Web site.
- Create a report on community benefits highlighting the hospital's services, programs, and activities that address identified community needs and share the report on the hospital Web site and with media outlets [7].

## References:

1. Wilson-Stronks A., Galvez E.: *Hospitals, Language, and Culture: A Snapshot of the Nation Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2007. Available at [http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). (Accessed April 15, 2010.)
2. American Medical Association, Ethical Force Program: *Improving Communication—Improving Care: How Health Care Organizations Can Ensure Effective, Patient-Centered Communication with People from Diverse Populations*. Chicago, IL: American Medical Association, 2006.
3. National Quality Forum (NQF): *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report*. Washington, DC: NQF, 2009. Available at

- [http://www.qualityforum.org/Publications/2009/04/A\\_Comprehensive\\_Framework\\_and\\_Preferred\\_Practices\\_for\\_Measuring\\_and\\_Reporting\\_Cultural\\_Competency.aspx](http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_Preferred_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx). (Accessed March 2, 2010.)
4. NRC Picker: Eight Dimensions of Patient-Centered Care. Lincoln, NE: National Research Center, 2008. Available at <http://www.nrcpicker.com/Measurement/Understanding%20PCC/Pages/DimensionsofPatient-CenteredCare.aspx>. (Accessed October 24, 2008.)
  5. Davis K., Schoenbaum S.C., Audet A.J.: A 2020 vision of patient-centered primary care. *J Gen Intern Med* 20(10):953-957, Oct. 2005.
  6. Planetree: Planetree Model—Acute-Care. Acute Care Components. Derby, CT: Planetree, Inc., 2008. Available at <http://planetree.org/about.html>. (Accessed October 24, 2008.)
  7. American Hospital Association (AHA): *AHA Guidance on Reporting of Community Benefit*. Chicago, IL: AHA, 2006. Available at <http://www.aha.org/aha/content/2006/pdf/061113cbreporting.pdf>. (Accessed March 2, 2010.)
  8. Office of Minority Health: *National Standards on Culturally and Linguistically Appropriate Services in Health Care*. Rockville, MD: U.S. Department of Health and Human Services, Office of Minority Health, 2001.
  9. Wilson-Stronks A., et al.: *One Size Does Not Fit All: Meeting The Health Care Needs of Diverse Populations*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2008. Available at [http://www.jointcommission.org/PatientSafety/HLC/one\\_size\\_meeting\\_need\\_of\\_diverse\\_populations.htm](http://www.jointcommission.org/PatientSafety/HLC/one_size_meeting_need_of_diverse_populations.htm) (Accessed April 9, 2010.)
  10. The Ethical Force Program: Advancing Ethics in Health Care. <http://www.ethicalforce.org>. (Accessed May 21, 2010.)
  11. Wynia M.K., et al.: Validation of an organizational communication climate assessment tool. *Am J Med Qual.* May 5, 2010 Online First. Available at <http://ajm.sagepub.com/cgi/rapidpdf/1062860610368428v1>. (Accessed May 13, 2010.)
  12. Frampton S., et al.: *Patient-Centered Care Improvement Guide*. Derby, CT: Planetree, Inc., and Picker Institute, 2008. Available at <http://www.planetree.org/Patient-Centered%20Care%20Improvement%20Guide%2010.10.08.pdf>. (Accessed March 1, 2010.)
  13. Andrulis D., et al.: *The Cultural Competence Self-Assessment Protocol for Health Care Organizations and Systems*. 2004. Available at <http://erc.msh.org/provider/andrulis.pdf>. (Accessed March 3, 2010.)
  14. Adaptive Environments Center, Inc., Barrier Free Environments, Inc.: *The Americans with Disabilities Act Checklist for Readily Achievable Barrier Removal*. Boston, MA: Adaptive Environments Center, Inc., Barrier Free Environments, 1995. Available at <http://www.ada.gov/checktxt.htm> or <http://www.ada.gov/rachek.pdf>. (Accessed March 2, 2010.)
  15. Delpercio A: *Healthcare Equality Index* 2009. Washington, DC: Human Rights Campaign Foundation and Gay and Lesbian Medical Association, 2009. Available at [http://www.hrc.org/documents/Healthcare\\_Equality\\_Index\\_2009.pdf](http://www.hrc.org/documents/Healthcare_Equality_Index_2009.pdf). Accessed March 2, 2010.
  16. White S., Dillow S.: *Key Concepts and Features of the 2003 National Assessment of Adult Literacy*. Washington, DC: National Center for Education Statistics, U.S. Department of Education, 2005. Available at <http://nces.ed.gov/NAAL/PDF/2006471.PDF>. (Accessed April 15, 2010.)
  17. Ulmer C., McFadden B., Nerenz D.: *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: The National Academies Press, 2009. Available at [http://books.nap.edu/openbook.php?record\\_id=12696](http://books.nap.edu/openbook.php?record_id=12696). (Accessed April 9, 2010.)
  18. Hasnain-Wynia R., et al.: *Health Research and Educational Trust Disparities Toolkit*. Chicago, IL: Health Research & Educational Trust, 2007. Available at <http://www.hretdisparities.org>. (Accessed March 2, 2010.)
  19. The Schwartz Center: *Schwartz Center Rounds® Toolkit*. Boston, MA: The Schwartz Center, 2008. Available at [http://www.theschwartzcenter.org/programs/rounds\\_kit.html](http://www.theschwartzcenter.org/programs/rounds_kit.html). (Accessed March 2, 2010.)
  20. The Center for Universal Design: *The Principles of Universal Design, Version 2.1*. Raleigh, NC: North Carolina State University, 1997. Available at [http://www.design.ncsu.edu/cud/about\\_ud/principleshtmlformat.html](http://www.design.ncsu.edu/cud/about_ud/principleshtmlformat.html). (Accessed on March 2, 2010.)
  21. Partnership for Clear Health Communication: Ask Me 3: What Can Providers Do? Boston: National Patient Safety Foundation, 2009. Available at [http://www.npsf.org/askme3/PCHC/what\\_can\\_provid.php](http://www.npsf.org/askme3/PCHC/what_can_provid.php). (Accessed March 1, 2010.)

22. King County: *Culturally Competent Care for GLBT People: Recommendations for Health Care Providers*. Seattle, WA: King County; 2010. Available at <http://www.kingcounty.gov/healthservices/health/personal/glb/CulturalCompetency.aspx>. (Accessed March 1, 2010.)
23. California Health Advocates: *Are You Practicing Cultural Humility? —The Key to Success in Cultural Competence*. Sacramento, CA: California Health Advocates, 2007. Available at <http://www.cahealthadvocates.org/news/disparities/2007/are-you.html>. (Accessed March 2, 2010.)
24. Spiritual Care Collaborative: Qualifications of professional chaplaincy in *Common Standards for Professional Chaplaincy*. Schaumburg, IL: Association of Professional Chaplains, 2004. Available at <http://professionalchaplains.org/uploadedFiles/pdf/common-standards-professional-chaplaincy.pdf>. (Accessed March 1, 2010.)





## Appendix A

# Checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care Across the Care Continuum

This checklist can be used as a quick reference to help catalogue your hospital's efforts to improve in the areas of effective communication, cultural competence, and patient- and family-centered care.

### **Admission**

- Inform patients of their rights.
- Identify the patient's preferred language for discussing health care.
- Identify whether the patient has a sensory or communication need.
- Determine whether the patient needs assistance completing admission forms.
- Collect patient race and ethnicity data in the medical record.
- Identify if the patient uses any assistive devices.
- Ask the patient if there are any additional needs that may affect his or her care.
- Communicate information about unique patient needs to the care team.

### **Assessment**

- Identify and address patient communication needs during assessment.
- Begin the patient-provider relationship with an introduction.
- Support the patient's ability to understand and act on health information.
- Identify and address patient mobility needs during assessment.
- Identify patient cultural, religious, or spiritual beliefs or practices that influence care.

- Identify patient dietary needs or restrictions that affect care.
- Ask the patient to identify a support person.
- Communicate information about unique patient needs to the care team.

### **Treatment**

- Address patient communication needs during treatment.
- Monitor changes in the patient's communication status.
- Involve patients and families in the care process.
- Tailor the informed consent process to meet patient needs.
- Provide patient education that meets patient needs.
- Address patient mobility needs during treatment.
- Accommodate patient cultural, religious, or spiritual beliefs and practices.
- Monitor changes in dietary needs or restrictions that may impact the patient's care.
- Ask the patient to choose a support person if one is not already identified.
- Communicate information about unique patient needs to the care team.

### **End-of-Life Care**

- Address patient communication needs during end-of-life care.
- Monitor changes in the patient's communication status during end-of-life care.

- Involve the patient's surrogate decision-maker and family in end-of-life care.
- Address patient mobility needs during end-of-life care.
- Identify patient cultural, religious, or spiritual beliefs and practices at the end of life.
- Make sure the patient has access to his or her chosen support person.

### **Discharge and Transfer**

- Address patient communication needs during discharge and transfer.
- Engage patients and families in discharge and transfer planning and instruction.
- Provide discharge instruction that meets patient needs
- Identify follow-up providers that can meet unique patient needs.

### **Organization Readiness**

#### **Leadership**

- Demonstrate leadership commitment to effective communication, cultural competence, and patient- and family-centered care.
- Integrate unique patient needs into new or existing hospital policies.

#### **Data Collection and Use**

- Conduct a baseline assessment of the hospital's efforts to meet unique patient needs.
- Use available population-level demographic data to help determine the needs of the surrounding community.
- Develop a system to collect patient-level race and ethnicity information.
- Develop a system to collect patient language information

- Make sure the hospital has a process to collect additional patient-level information .

### **Workforce**

- Target recruitment efforts to increase the pool of diverse and bilingual candidates.
- Ensure the competency of individuals providing language services.
- Incorporate the issues of effective communication, cultural competence, and patient- and family-centered care into new or existing staff training curricula.
- Identify staff concerns or suggested improvements for providing care that meets unique patient needs.

### **Provision of Care, Treatment, and Services**

- Create an environment that is inclusive of all patients.
- Develop a system to provide language services.
- Address the communication needs of patients with sensory or communication impairments.
- Integrate health literacy strategies into patient discussions and materials.
- Incorporate cultural competence and patient- and family-centered care concepts into care delivery.

### **Patient, Family, and Community Engagement**

- Collect feedback from patients, families, and the surrounding community.
- Share information with the surrounding community about the hospital's efforts to meet unique patient needs.





## Appendix B

# CURRENT JOINT COMMISSION REQUIREMENTS

## SUPPORTING EFFECTIVE COMMUNICATION, CULTURAL COMPETENCE, AND PATIENT- AND FAMILY-CENTERED CARE

Joint Commission standards have supported the provision of care, treatment, and services in a manner that is sensitive and responsive to individual patient needs for many years.

Recognition of the role patients and their families play in patient safety promotes practices that increase patients' and families' ability to actively engage in their care. Since care spans a broad continuum and involves a complex interplay of both individual and system behaviors, the standards that support effective communication, cultural competence, and patient- and family-centered care are found throughout the *Comprehensive Accreditation Manual for Hospitals (CAMH)*.

This appendix presents these existing standards and elements of performance (EPs) with brief notes about how they relate to and support effective communication, cultural competence, and patient- and family-centered care. Appendix C (page 57) presents new Joint Commission standards for patient-centered communication.

Standards from the following *CAMH* chapters are included in this appendix:

- Environment of Care (EC)
- Emergency Management (EM)
- Human Resources (HR)
- Leadership (LD)
- Provision of Care, Treatment, and Services (PC)
- Rights and Responsibilities of the Individual (RI)
- Transplant Safety (TS)

The standards are up-to-date as of April 2010. For full text of these standards, please refer to the *CAMH*.

Not all scenarios can be considered or covered in a brief appendix; in some cases we refer to other sections of the *Roadmap for Hospitals* that provide detailed examples and guidance for addressing a specific issue.

### Environment of Care (EC)

The Joint Commission EC standards primarily address the physical safety of the environment for patients, staff, and visitors. However, the chapter also recognizes that the physical environment needs to support patient privacy, dignity, and foster ease of interaction (*see box, below*). EC standards also support an environment that is compliant with the Americans with Disabilities Act, Occupational Safety and Health Administration (OSHA) regulations, and other environmental safety codes.

#### Joint Commission EC Requirements

**EC.02.06.01** The hospital establishes and maintains a safe, functional environment.

**Note:** *The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.*

**EP 1** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

## Emergency Management (EM)

The Joint Commission's EM standards provide guidance to hospitals about how to plan for and respond to potential emergencies. While these standards do not explicitly address effective communication, cultural competence, and patient- and family-centered care, it is necessary to consider the diverse needs of the patient and community population so that emergency response efforts provide for the safety of all who require hospital services (*see* box, right). For example, decontamination instructions provided to patients by staff should not only be verbal, but should also be in the form of posters or other visual aides for patients who are deaf or have limited English proficiency.

The hospital may also want to consider ethnic media as sources for communicating information to minority populations. The “vulnerable populations” referenced in Standard EM. 02.02.11, EP 4, may also include individuals with limited English proficiency or other communication needs.

## Human Resources (HR)

Many recommendations to promote effective communication, cultural competence, and patient- and family-centered care include recommendations to build a diverse workforce through recruitment, retention, and promotion of diverse staff. The Joint Commission standards do not set this specific expectation. Instead, Joint Commission standards expect that hospital staffing is consistent with the organization's mission. In addition, The Joint Commission expects the organization's leadership to define the qualifications and competencies of staff (*see* Leadership on page 51).

From this perspective, HR standards focus mainly on the specific skill sets and competencies that staff need to perform their job. Joint Commission standards address orientation on cultural diversity and sensitivity, and expect ongoing in-services and other education and training to be appropriate to the needs of the population(s) served and responsive to learning needs identified through performance improvement findings and other data analysis (*see* box, page 51). Staff must be aware of relevant policies and procedures, which could include the hospital's policies for meeting patient communication needs. Communication is recognized as a patient right, but is also clearly part of the provision of safe care. It is vital to make staff aware of how to identify and address patient communication needs within the scope of their job duties.

### Joint Commission EM Requirements

**EM.02.02.01** As part of its Emergency Operations Plan, the hospital prepares for how it will communicate during emergencies.

#### Rationale for EM.02.02.01

The hospital maintains reliable communications capabilities for the purpose of communication response efforts to staff, patients, and external organizations. The hospital establishes backup communications processes and technologies (for example, cell phones, land lines, bulletin boards, fax machines, satellite phones, Amateur Radio, text messages) to communicate essential information if primary communication systems fail.

**EP 5** The Emergency Operations Plan describes the following: How the hospital will communicate with patients and their families, including how it will notify families when patients are relocated to alternative care sites.

**EP 6** The Emergency Operations Plan describes the following: How the hospital will communicate with the community or the media during an emergency.

**EM.02.02.11** As part of its Emergency Operations plan, the hospital prepares for how it will manage patients during emergencies.

#### Rationale for EM.02.02.11

The fundamental goal of emergency management planning is to protect life and prevent disability. The manner in which care, treatment, and services are provided may vary by type of emergency. However, certain activities are so fundamental to patient safety (this can include decisions to modify or discontinue services, make referrals, or transport patients) that the organization should take a proactive approach in considering how they might be accomplished.

The emergency triage process will typically result in patients being quickly treated and discharged, admitted for a longer stay, or transferred to a more appropriate source of care.

**EP 4** The Emergency Operations Plan describes the following: How the hospital will manage a potential increase in demand for clinical services for vulnerable populations served by the hospital, such as patients who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions.

It may also be appropriate to provide staff training on the cultural health beliefs and practices of the patient population if they differ from those of staff. In addition to having a diverse patient population, many hospitals also operate with a diverse staff and medical staff. Training and coaching to

**Joint Commission HR Requirements****HR.01.02.01** The hospital defines staff qualifications.

**EP 1** The hospital defines staff qualifications specific to their job responsibilities.

**HR.01.04.01** The hospital provides orientation to staff.

**EP 3** The hospital orients staff on the following: Relevant hospitalwide and unit-specific policies and procedures. Completion of this orientation is documented.

**EP 4** The hospital orients staff on the following: Their specific job duties, including those related to infection prevention and control and assessing and managing pain. Completion of this orientation is documented.

**EP 5** The hospital orients staff on the following: Sensitivity to cultural diversity based on their job duties and responsibilities. Completion of this orientation is documented.

**EP 6** The hospital orients staff on the following: Patient rights, including ethical aspects of care, treatment, and services and the process used to address ethical issues based on their job duties and responsibilities. Completion of this orientation is documented.

**HR.01.05.03** Staff participate in ongoing education and training.

**EP 1** Staff participate in ongoing education and training to maintain or increase their competency. Staff participation is documented.

**EP 4** Staff participate in ongoing education and training whenever staff responsibilities change. Staff participation is documented.

**EP 5** Staff participate in education and training that is specific to the needs of the patient population served by the hospital. Staff participation is documented.

**HR.01.06.01** Staff are competent to perform their responsibilities.

**EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services.

improve understanding between these groups can be an effective way to promote both patient and staff satisfaction.

**Leadership (LD)**

LD standards address the foundational elements that support effective systems for providing quality care, treatment, and services; the organization culture; systems and policy development; availability of resources; availability of competent

staff; and ongoing evaluation of and improvement in performance. The organization support systems that allow for effective patient–provider communication, cultural competence, and patient- and family-centered care all hinge upon leadership (*see box, page 52*).

The mission of many hospitals is to meet the needs of the patient population and their communities. Leaders must reconcile these needs with the organization’s resources and needs. For example, supports for effective communication do not only benefit the needs of the patient, but equally benefit the needs of the care providers and the hospital. The *Hospitals, Language, and Culture: A Snapshot of the Nation* study found that several hospitals invested in language access services to improve communication because they recognized that the lack of available interpreters potentially contributed to patient flow problems, overuse of certain tests, and unnecessary readmissions [1].

In addition, experts in the area of patient- and family-centered care recommend that leaders bring the patient and family perspective directly into the planning, delivery, and evaluation of health care. Studies increasingly show that when health care administrators, providers, and patients and families work in partnership, the quality and safety of health care rise, costs decrease, and provider and patient satisfaction increase.

LD standards support the concepts outlined in the *Roadmap for Hospitals* in many areas, including the following:

- Communication of the hospital’s mission, including supportive systems to effectively communicate throughout the hospital and to the community
- The use of data to plan for and monitor care, treatment, and services
- Creation of a culture that supports patient and staff safety
- Compliance with applicable laws and regulations, including those that protect patients’ rights, equal opportunity for workforce, and environmental regulations such as building and safety codes. (*See Appendix D: Laws and Regulations, page 65, for more information on some of the laws and regulations relevant to effective communication, cultural competence, and patient- and family-centered care.*)

Many hospitals include in their mission and/or vision statements the commitment to serve their community. Often, it is this commitment that drives hospital leaders to embrace practices that support health equity.

## Joint Commission LD Requirements

**LD.02.01.01** The mission, vision, and goals of the hospital support the safety and quality of care, treatment, and services.

### Rationale for LD.02.01.01

The primary responsibility of leaders is to provide for the safety and quality of care, treatment, and services. The purpose of the hospital's mission, vision, and goals, is to define how the hospital will achieve safety and quality. The leaders are more likely to be aligned with the mission, vision, and goals when they create them together. The common purpose of the hospital is most likely achieved when it is understood by all who work in or are served by the hospital.

**EP 3** Leaders communicate the mission, vision, and goals to staff and the population(s) the hospital serves.

**LD.03.02.01** The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

### Rationale for LD.03.02.01

Data help hospitals make the right decisions. When decisions are supported by data, hospitals are more likely to move in directions that help them achieve their goals. Successful hospitals measure and analyze their performance. When data are analyzed and turned into information, this process helps hospitals see patterns and trends and understand the reasons for their performance. Many types of data are used to evaluate performance, including data on outcomes of care, performance on safety and quality initiatives, patient satisfaction, process variation, and staff perceptions.

**EP 3** The hospital uses processes to support systematic data and information use.

**EP 5** The hospital uses data and information in decision-making that supports the safety and quality of care, treatment, and services.

**LD.03.04.01** The hospital communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.

### Rationale for LD.03.04.01

Effective communication is essential among individuals and groups within the hospital, and between the hospital and external parties. Poor communication often contributes to adverse events and can compromise safety and quality of care, treatment, and services. Effective communication is timely, accurate, and usable by the audience.

**EP 1** Communication processes foster the safety of the patient and the quality of care.

**EP 3** Communication is designed to meet the needs of internal and external users.

**EP 5** Communication supports safety and quality throughout the hospital.

**EP 6** When changes in the environment occur, the hospital communicates those changes effectively.

**LD.04.01.01** The hospital complies with law and regulation.

**EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations.

**LD.04.03.07** Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.

### Rationale for LD.04.03.07

Comparable standards of care means that the hospital can provide the services that patients need within established time frames and that those providing care, treatment, and services have the required competence. Hospitals may provide different services to patients with similar needs as long as the patient's outcome is not affected. For example, some patients may receive equipment with enhanced features because of insurance situations. This does not ordinarily lead to different outcomes. Different settings, processes, or payment sources should not result in different standards of care.

**EP 1** Variances in staff, setting, or payment source do not affect outcomes of care, treatment, and services in a negative way.

**EP 2** Care, treatment, and services are consistent with the hospital's mission, vision, and goals.

## Joint Commission PC Requirements

### PC.01.02.01 The hospital assesses and reassesses its patients.

**EP 1** The hospital defines, in writing, the scope and content of screening, assessment, and reassessment information it collects.

**Note:** *In defining the scope and content of the information it collects, the organization may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry.*

**EP 2** The hospital defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed.

**Note:** *Examples of criteria could include those that identify when a nutritional, functional, or pain assessment should be performed for patients who are at risk.*

**EP 4** Based on the patient's condition, information gathered in the initial assessment includes the following:

- Physical, psychological, and social assessment
- Nutrition and hydration status
- Functional status
- For patients who are receiving end-of-life care, the social, spiritual, and cultural variables that influence the patient's and family members' perception of grief

### PC.01.03.01 The hospital plans the patient's care.

**EP 1** The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing.

### PC.02.02.01 The hospital coordinates the patient's care, treatment, and services based on the patient's needs.

**EP 1** The hospital has a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services.

**EP 3** The hospital coordinates the patient's care, treatment, and services.

**Note:** *Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services.*

**EP 10** When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services.

**EP 17** The hospital coordinates care, treatment, and services within a time frame that meets the patient's needs.

### PC.02.02.03 The hospital makes food and nutrition products available to its patients.

**EP 9** When possible, the hospital accommodates the patient's cultural, religious, or ethnic food and nutrition preferences, unless contraindicated.

### PC.02.02.13 The patient's comfort and dignity receive priority during end-of-life care.

**EP 1** To the extent possible, the hospital provides care and services that accommodate the patient's and his or her family's comfort, dignity, psychosocial, emotional, and spiritual end-of-life needs

### PC.02.03.01 The hospital provides patient education and training based on each patient's needs and abilities.

**EP 1** The hospital performs a learning needs assessment for each patient, which includes the patient's cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.

## Provision of Care, Treatment, and Services (PC)

PC standards address the cyclical process that allows care to be delivered according to patient needs and the hospital's scope of services [2]. Existing Joint Commission PC standards address care at various points across the care continuum. The Joint Commission recognizes the need for patients and families to be active and informed decision makers throughout the course of care (*see* box, above). In order to establish this partnership between the care provider and patient, it is necessary to make sure that communication is effective.

Part of patient assessment includes the identification of patient learning needs. In addition, the assessment process may allow for comprehensive evaluation of other needs that may impact the patient's ability to engage with the care team. These needs are important to consider throughout the care continuum. Patient's communication needs, cultural perspective of health and health care, and previous experience with the health system all influence how the patient will respond to care. In order to foster a healthy relationship with the patient during the course of care, it is necessary to be sensitive and open to the patient's individual perspective. Many standards in the PC chapter support this.

## Joint Commission RI Requirements

**RI.01.01.01** The hospital respects, protects, and promotes patient rights.

**EP 2** The hospital informs the patient of his or her rights.

**EP 5** The hospital respects the patient's right to and need for effective communication.

**EP 6** The hospital respects the patient's cultural and personal values, beliefs, and preferences.

**EP 9** The hospital accommodates the patient's right to religious and other spiritual services.

**RI.01.01.03** The hospital respects the patient's right to receive information in a manner he or she understands.

**EP 1** The hospital provides information in a manner tailored to the patient's age, language, and ability to understand.

**EP 2** The hospital provides interpreting and translation services, as necessary.

**EP 3** The hospital communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.

**RI.01.02.01** The hospital respects the patient's right to participate in decisions about his or her care, treatment, and services.

**EP 1** The hospital involves the patient in making decisions about his or her care, treatment, and services.

**RI.01.03.01** The hospital honors the patient's right to give or withhold informed consent.

### Rationale for RI.01.03.01

Obtaining informed consent presents an opportunity to establish a mutual understanding between the patient and the licensed independent practitioner or other licensed practitioners with privileges about the care, treatment, and services that the patient will receive. Informed consent is not merely a signed document. It is a process that considers patient needs and preferences, compliance with law and regulation, and patient education. Utilizing the informed consent process helps the patient to participate fully in decisions about his or her care, treatment, or services.

**EP 13** Informed consent is obtained in accordance with the hospital's policy and processes and, except in emergencies, prior to surgery.

**RI.01.05.01** The hospital addresses patient decisions about care, treatment, and services received at the end of life.

**EP 6** The hospital provides patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services.

**EP 8** Upon admission, the hospital provides the patient with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives.

**EP 10** Upon request, the hospital refers the patient to resources for assistance in formulating advance directives.

**RI.01.06.03** The patient has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.

**EP 1** The hospital determines how it will protect the patient from neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services within the hospital.

**RI.01.07.01** The patient and his or her family have the right to have complaints reviewed by the hospital.

### Rationale for RI.01.07.01

A business is often judged by how it handles dissatisfied customers; the same is true for health care organizations. Addressing complaints promptly helps to satisfy the needs of patients and their families during a vulnerable time in their lives, and may also prevent adverse events from occurring in the organization. Complaints can range from the straightforward, such as the temperature of the patient's room, to the complex, such as the patient's care being adversely impacted by practitioners' failure to effectively communicate. Regardless of the complexity of the complaint, patients and their families expect the organization to work toward a resolution as quickly as possible.

**EP 1** The hospital establishes a complaint resolution process.

**Note:** *The governing body is responsible for the effective operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee.*

**EP 2** The hospital informs the patient and his or her family about the complaint resolution process.

**EP 4** The hospital reviews and, when possible, resolves complaints from the patient and his or her family.

**EP 7** The hospital provides the patient with the phone number and address needed to file a complaint with the relevant state authority.

**EP 10** The hospital allows the patient to voice complaints and recommend changes freely without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care.

## Rights and Responsibilities of the Individual (RI)

Hospital care must be provided in a manner that is respectful of individual values, beliefs, and preferences. While not all preferences can be accommodated, it is highly desirable to work with patients to achieve a negotiated solution when differences arise. The standards in the RI chapter highlight the need for patient engagement in health care (*see* box, page 54). The patient is a key decision maker and a key source of information so that accurate assessment and diagnosis can be made. Patient rights standards support patient engagement in a manner that promotes understanding so that the provision of care is not compromised.

## Transplant Services

The transplant services chapter addresses considerations for donating and procuring organs and tissues. Since there are a variety of cultural beliefs and rituals associated with death, as well as beliefs about how the physical body should be cared for

## References:

1. Wilson-Stronks A., Galvez E.: *Hospitals, Language, and Culture: A Snapshot of the Nation Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2007. Available at [http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc\\_paper.pdf](http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf). (Accessed April 15, 2010.)
2. The Joint Commission: *2010 Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace, IL: Joint Commission Resources, 2010.

### Joint Commission TS Requirements

**TS.01.01.01** The hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs and tissues.

**EP 5** Staff education includes training in the use of discretion and sensitivity to the circumstances, beliefs, and desires of the families of potential organ, tissue, or eye donors.

before and after death, it is important that these beliefs are considered when proposing organ donation and procurement. Staff should be trained to be aware and respectful of cultural and religious beliefs that may influence how a patient or family will respond to inquiries about organ donation (*see* box, above).







# Appendix C

## NEW JOINT COMMISSION STANDARDS

### FOR PATIENT-CENTERED COMMUNICATION

In January 2010, The Joint Commission released a set of new and revised standards for patient-centered communication as part of its project to advance effective communication, cultural competence, and patient- and family-centered care. These standards, designed to improve the safety and quality of care for all patients and to inspire hospitals to adopt practices promoting better communication and patient engagement, are highlighted here in Appendix C in the shaded boxes. Any new or revised content in the standards is underlined, and deleted content is identified by ~~struckthrough~~ text. This appendix includes standards and elements of performance (EPs) from the following chapters from the *Comprehensive Accreditation Manual for Hospitals*:

- Human Resources (HR)
- Provision of Care, Treatment, and Services (PC)
- Record of Care, Treatment, and Services (RC)
- Rights and Responsibilities of the Individual (RI)

Joint Commission surveyors will evaluate compliance with the patient-centered communication standards beginning January 1, 2011; however, findings will not affect the accreditation decision. The information collected by Joint Commission surveyors and staff during this implementation pilot phase will be used to address common implementation questions and concerns. Compliance with the patient-centered communication standards will be included in the accreditation decision no earlier than January 2012.

The following information accompanies each revised standard:

- **Explanation of Revision** contains background information and additional context for the standard.
- **Self-Assessment Guidelines** includes information that hospitals should consider when determining how to meet

the intent of the standard or references to specific survey activities that address the standard.

- **Recommendations from the *Roadmap*** refers readers to the detailed information within guidelines referenced in Chapters 1 to 6 of the *Roadmap for Hospitals*.

The recommendations from the *Roadmap* represent a variety of ways a hospital can comply with these new standards; some may not apply to all hospital types, sizes, or settings. As there is no “one size fits all” solution, we encourage hospitals to use the guidelines and recommendations as a foundation to create processes, policies, and programs that best suit their organizations. (Please refer to the Table of Contents to locate the chapters that address each recommendation.)

### Human Resources (HR)

The HR chapter addresses the hospital’s responsibility to establish and verify staff qualifications, orient staff, and provide staff with the training they need to support the care, treatment, and services the hospital provides.

#### New Joint Commission HR Requirement

##### HR.01.02.01 The hospital defines staff qualifications.

- EP 1** The hospital defines staff qualifications specific to their job responsibilities.

**Note 4:** Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. (Inclusion of these qualifications will not affect the accreditation decision at this time.)

### HR.01.02.01: Explanation of Revision

It is not appropriate to rely on untrained individuals as the primary source for bridging communication barriers during medical encounters with individuals who are deaf or speak a language other than English. Requirement HR.01.02.01, EP 1, requires hospitals to define staff qualifications specific to job responsibilities. Note 4 in EP 1 requires hospitals to specifically ensure that individuals who provide interpreting or translation services in the hospital have defined qualifications and competencies. The research literature demonstrates that relying on untrained individuals as interpreters is more likely to result in misinterpretation [1, 2], lower quality of care [3], or could even contribute to an adverse event [4, 5]. Untrained individuals—including family members, friends, other patients, or untrained bilingual staff—should not be used to provide language access services during medical encounters. It may be appropriate to use untrained individuals for social conversations or to convey or receive simple messages, provided that the messages or the use of such untrained individuals do not infringe upon the patient’s confidentiality.

In addition to language proficiency, individuals used to interpret or translate also must possess a set of skills and follow professional practice standards and a code of ethics.\* Appendix E (page 82) contains resources with further information about the skills, standards, and ethics of interpreting and translating. It is important to recognize that qualified interpreters may not be available at every encounter. Hospitals have many options for providing interpreter services, including using qualified bilingual staff, hiring full or part-time professional interpreters, contracting for interpreter services directly with an individual interpreter or through an agency, or through the use of volunteers who are appropriately qualified. Regardless of the relationship, individuals who provide these services must be competent and proficient in both the target language and English. For more information about providing interpreter services, *see* Workforce (page 37) and Provision of Care, Treatment, and Services (page 39) in Chapter 6: Organization Readiness and Appendix E: Resource Guide (page 80).

The requirement to provide qualified language access services reflects current law and regulation. Requirements for the provision of interpreter and translation services is covered by the

Americans with Disabilities Act, Section 504 of the Rehabilitation Act and Title VI of the Civil Rights Act.

For more information about these laws, *see* Appendix D: Laws and Regulations (page 67).

### Self-Assessment Guidelines

- A job description for interpreters includes defined competencies such as language proficiency (in target language and English), skills required, and training needed.
- Human resources files for individuals who are used to interpret include evidence of their competency assessment as outlined in the job description.
- Interviews with individuals used to interpret include discussion about training, experience, and qualifications.
- For contracted interpreter services (either via phone, video, or in person), the hospital receives assurance that the contract includes information about how the service provider defines competencies consistent with your hospital’s defined expectations. (Joint Commission Leadership Standard LD.04.03.09 specifically addresses the provision of contracted services within the hospital.)

### Recommendations from the Roadmap

- Integrate unique patient needs into new or existing hospital policies.
- Ensure the competency of individuals providing language services.

### Provision of Care, Treatment, and Services (PC)

The PC chapter focuses on the integrated and cyclical process that allows care to be delivered according to patient needs and the hospital’s scope of services. The complexity of providing care, treatment, and services through this process often demands an interdisciplinary collaborative approach and a mutual effort from those who work in the organization to coordinate care in a manner that is conducive to optimal patient outcomes, quality, and safety.

### PC.02.01.21: Explanation of Revision

The new Standard PC.02.01.21 emphasizes the importance of effective communication between patients and their providers of care, treatment, and services. Research has shown that effective patient–provider communication is necessary for patient

\* Consult the National Council on Interpreting in Health Care, the Registry of Interpreters for the Deaf, and the American Translators Association for additional guidance on the qualifications and competencies for language interpreters and translators.

## New Joint Commission PC Requirements

**PC.02.01.21** The hospital effectively communicates with patients when providing care, treatment, and services.

**Note:** This standard will not affect the accreditation decision at this time.

### Rationale for PC.02.01.21

This standard emphasizes the importance of effective communication between patients and their providers of care, treatment, and services. Effective patient-provider communication is necessary for patient safety. Research shows that patients with communication problems are at an increased risk of experiencing preventable adverse events,<sup>\*</sup> and that patients with limited English proficiency are more likely to experience adverse events than English speaking patients.<sup>†‡</sup>

Identifying the patient's oral and written communication needs is an essential step in determining how to facilitate the exchange of information with the patient during the care process. Patients may have hearing or visual needs, speak or read a language other than English, experience difficulty understanding health information, or be unable to speak due to their medical condition or treatment. Additionally, some communication needs may change during the course of care. Once the patient's communication needs are identified, the hospital can determine

the best way to promote two-way communication between the patient and his or her providers in a manner that meets the patient's needs. This standard complements RI.01.01.01, EP 5 (patient right to and need for effective communication); RI.01.01.03, EP 2 (provision of language interpreting and translation services); and RI.01.01.03, EP 3 (meeting needs of patients with vision, speech, hearing, or cognitive impairments).

**EP 1** The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. (See also RC.02.01.01, EP 1)

**Note 1:** Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.

**Note 2:** This element of performance will not affect the accreditation decision at this time.

**EP 2** The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. (See also RI.01.01.03, EPs 1-3)

**Note:** This element of performance will not affect the accreditation decision at this time.

\* Bartlett G., et al: Impact of patient communication problems on the risk of preventable adverse events in acute care settings. *CMAJ* 178(12):1555-1562, Jun. 3, 2008.

† Divi C, Koss R.G., Schmaltz S.P., Loeb J.M.: Language proficiency and adverse events in U.S. hospitals: A pilot study. *Int J Qual Health Care* 19(2):60-67, Apr. 2007.

‡ Cohen A.L., et al: Are language barriers associated with serious medical events in hospitalized pediatric patients? *Pediatrics* 116(3):575-9, Sep. 2005.

safety [4,5]. PC.02.01.21, EP 1, complements existing requirement RI.01.01.01, EP 5, which focuses on the patient's right to and need for effective communication. The new requirement emphasizes the need to promote two-way communication between the patient and the provider. Identifying a patient's communication need is an essential step in determining how to best facilitate the exchange of information with the patient during the care process.

Note 1 at PC.02.01.21, EP 1, provides several examples of communication needs to raise awareness that needs range from the obvious to the subtle. EP 1 uses the phrase "preferred language for discussing health care." While some patients may be able to converse at a basic level in English, they may require an interpreter during complex medical discussions to fully understand, especially during stressful conversations. EP 2 is not intended to require that every written material be translated into every pa-

tient language, but to make sure that the hospital takes into consideration a specific need a patient has for written materials. For example, if a patient only reads in Russian, and patient education materials are not available in that language, other means of supporting patient education should take place. Or, if a patient uses glasses to read, staff must make sure that the patient's glasses are accessible when using written materials during patient education. (For guidance on determining which and how many languages to translate written materials, see Appendix D: Laws and Regulations, page 65.)

## Self-Assessment Guidelines

- Observe how services are provided to verify that patient's oral and written communication needs are identified and addressed during the course of care. For example, is the nurse call button accessible to the patient? Does a staff member respond in person, instead of using the intercom,

when a call button is pushed by a patient who is deaf? Are interpreter services arranged for patients who are deaf and communicate through sign language? Are communication boards available in areas where patients are likely to be intubated or otherwise unable to speak such as the intensive care unit or surgical recovery?

- Review the medical record to verify that staff identified oral and written communication needs.
- If a communication need is identified, follow up with an interview with the patient to ensure communication needs were addressed.
- Review complaint data from patients and staff.
- Conduct administrative rounds focused on patient communication.
- Note if available communication resources are available for clinical rounds at key points of care such as in exam rooms, at nursing stations, and in patient care rooms.
- Provide staff training module on how to address patient communication needs such as how to access and work with an interpreter, how to use a communication board, and effective communication techniques to support patient understanding (such as teach back).

### Recommendations from the Roadmap

- Identify the patient's preferred language for discussing health care.
- Identify whether the patient has a sensory or communication need.
- Address patient communication needs.
- Support the patient's ability to understand and act on health information.
- Monitor changes in the patient's communication status.
- Integrate unique patient needs into new or existing hospital policies.

### Record of Care, Treatment, and Services (RC)

The RC chapter contains information about the components of a complete medical record. Whether the hospital keeps paper records, electronic records, or a combination of both, the contents of the record remain the same.

#### RC.02.01.01: Explanation of Revision

The collection of patient-level demographic data on language, race, and ethnicity is a crucial component of the process to identify health care needs and eliminate disparities. The revision to RC.02.01.01, EP 1, expands on the current requirement to collect data on the patient's communication needs, and new EP 28 includes the collection of race and ethnicity data in the medical record. These requirements will ensure that language, race, and ethnicity information is available for each patient so the hospital has an opportunity to better plan for needed services. Collecting these data also facilitates monitoring service provision and analyzing disparities in care.

### New Joint Commission RC Requirements

**RC.02.01.01** The medical record contains information that reflects the patient's care, treatment, and services.

- EP 1** The medical record contains the following demographic information:
- The patient's name, address, date of birth, and the name of any legally authorized representative
  - The patient's sex
  - The legal status of any patient receiving behavioral health care services
  - The patient's ~~language and~~ communication needs, including preferred language for discussing health care (See also PC.02.01.21, EP 1)

**Note:** *If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative are documented in the medical record.*

- EP 28** The medical record contains the patient's race and ethnicity.

**Note:** *This element of performance will not affect the accreditation decision at this time.*

Joint Commission standards do not specify how to categorize data when collecting race and ethnicity data. However, many state reporting entities and payors do specify these requirements. It is important for each hospital to determine how it wishes to collect the data and what its reporting requirements are.

Joint Commission standards do not specify how to categorize data when collecting race and ethnicity data. However, many state reporting entities and payors do specify these requirements. It is important for each hospital to determine how it wishes to collect the data and what its reporting requirements are.

### Self-Assessment Guidelines

- Review the hospital policy for collecting patient demographic data. The policy may specify who, how, when, what, and where information is recorded.
- Interview staff regarding knowledge of the process for collecting patient-level data on race, ethnicity, and communication needs.

### New Joint Commission RI Requirements

**RI.01.01.01** The hospital respects, protects, and promotes patient rights.

**EP 28** The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.

**Note 1:** The hospital allows for the presence of a support individual of the patient's choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient's surrogate decision-maker or legally authorized representative.

(For more information on surrogate or family involvement in patient care, treatment, and services, refer to RI.01.02.01, EPs 6-8.)

**Note 2:** This element of performance will not affect the accreditation decision at this time.

**EP 29** The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

**Note:** This element of performance will not affect the accreditation decision at this time.

- Review the medical record to verify that it contains the patient's communication needs, including preferred language for discussing health care.
- Review the medical record to verify that it contains the patient's race and ethnicity information.

### Recommendations from the Roadmap

- Develop a system to collect patient language information.
- Identify the patient's preferred language for discussing health care.
- Identify whether the patient has a sensory or communication need.
- Develop a system to collect patient-level race and ethnicity information.

### Rights and Responsibilities of the Individual (RI)

The standards in the RI chapter address informing patients of their rights; helping patients understand and exercise their rights; respecting patients' values, beliefs, and preferences; and informing patients of their responsibilities regarding their care, treatment, and services.

### R1.01.01.01, EP 28: Explanation of Revision

Patients have the right to access a support person during their care provided that it does not interfere with the rights of other patients or interfere with the care process. Standard RI.01.01.01 addresses a variety of patient rights issues, and the new requirement under EP 28 will allow a family member, friend, or other individual to be present with the patient to provide emotional support, comfort, and alleviate fear during the course of the hospital stay. This requirement, which is not meant to eliminate visitation hours or permit large groups of people to stay with the patient, should help hospitals further incorporate the concepts of patient- and family-centered care. Note 1 included with EP 28 provides guidance on the parameters of compliance for the hospital and the potential limitations regarding the role of the support person in care decisions.

While this standard is not intended to dictate hospital visitation policy, it is intended to raise awareness of the need for visitation policies that are inclusive of those whom the patient identifies as important. The Joint Commission expanded its definition of *family* to include individuals who may not be legally related to the patient, including someone who serves as the patient's support person.

It is important for the hospital to understand who the patient wishes to involve in the care process and to involve that person, especially if that person is going to be providing ongoing care after discharge from the hospital. The hospital should document this information or otherwise communicate it to the care team.

Patients should have a trusted friend or family member with them during health care discussions as a way to help promote understanding. It is also important to consider situations involving an incapacitated patient. Patients who are unable to communicate or speak up for themselves are especially vulnerable. The hospital should always accommodate access to the patient's health care support person to support the patient's wishes and safety.

### Self-Assessment Guidelines

- Interview staff regarding knowledge of how the hospital supports patient's right to a support person.
- Review process for supporting patients' right to designate a support person.
- Clinical rounds, patient education sessions, and discharge planning accommodate the patient's right to have a support person present.

- Hospital visitation policy does not prohibit access to the identified support person.

**Recommendations from the Roadmap**

- Inform patients of their rights.
- Ask the patient to identify a support person.
- Involve patients and families in the care process.
- Integrate unique patient needs into new or existing hospital policies.

**RI.01.01.01, EP 29:  
Explanation of Revision**

Standard RI.01.01.01 addresses a variety of patient rights issues. New requirement EP 29 addresses the patient’s right to receive care, treatment, and services free from discrimination based on various personal characteristics. Although several laws and regulations include anti-discrimination protections, state laws vary. EP 29 underscores the importance of providing equitable care to all patients and applies to accredited hospitals nationwide.

In some circumstances, a hospital may refuse to perform a specific procedure that conflicts with the hospital’s mission, vision, and goals. A refusal of care in this instance is not considered to be an act of discrimination. However, a patient may not be refused care because of personal characteristics.

**Self-Assessment Guidelines**

- Review hospital mission and vision statements.
- Review patients’ rights documents.
- Review patient and staff complaint data.
- Review patient and staff satisfaction data.
- Review policies and procedures regarding nondiscrimination during the provision of care.
- Review the hospital’s complaint resolution process.

**Recommendations from the Roadmap**

- Inform patients of their rights.
- Integrate unique patient needs into new or existing hospital policies.
- Incorporate the issues of effective communication, cultural competence, and patient- and family-centered care into new or existing staff training curricula.
- Collect feedback from patients, families, and the surrounding community.

**New Joint Commission RI Requirements**

**RI.01.01.03** The hospital respects the patient’s right to receive information in a manner he or she understands.

**EP 2** The hospital provides language interpreting and translation services, as necessary. (See also RI.01.01.01, EPs 2 and 5; PC.02.01.21, EP 2; HR.01.02.01, EP 1)

*Note: Language interpreting options may include hospital-employed language interpreters, contract interpreting services, or trained bilingual staff. These options may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.*

**EP 3** The hospital provides information to communicate with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient’s needs. (See also RI.01.01.01, EPs 2 and 5; PC.02.01.21, EP 2)

**RI.01.01.03:  
Explanation of Revision**

Standard RI.01.01.03 addresses the patient’s right to receive information in a manner he or she understands. The current requirements highlight the importance of addressing various patient communication needs and tailoring information to improve patient comprehension. The editorial revision and new Note to EP 2 clarify expectations to provide language interpreters and translated documents and maintain consistency with the existing Standard RI.01.01.03, EP 1. A reference to new requirement PC.02.01.21, EP 2, connects the patient’s right to understand information with the patient–provider communication that occurs during the care process. See Chapter 6: Organization Readiness (page 40) for detailed information about developing appropriate language access services. Appendix D: Laws and Regulations (page 65) provides additional guidance about the legal requirements for translating written material and Appendix E: Resource Guide (page 80) provides references to additional resources to help in this area.

**Self-Assessment Guidelines**

- Verify that the hospital has a system to provide interpreter services for patients who are deaf or who do not speak English.
- Interview staff at key points of care to make sure that they know how to access interpreter services and obtain available translated documents.

- Observe patient care units to determine how patients' needs are supported. Does the patient have access to the nurse call button? What attempts have been made to support communication?
- Observe utilization of language interpreting and translation services during a patient tracer activity. Are staff familiar with how to work with an interpreter? Are interpreters considered part of the care team?
- Review frequency of use of interpreter services against patient population demographics. Are interpreters used when needed?
- Review medical record for inclusion of vital documents in appropriate language for patient, if available. If vital documents are not available, the record should demonstrate how information was communicated to patient.
- Review policies and procedures for information on providing language interpreting and translation services. Does the hospital have a language access plan?
- Review training documents to see how staff are trained to accommodate various communication needs.
- If the hospital has a speech pathology or audiology department, interview staff in that department to see how they are used as a resource for meeting patient communication needs and training staff on available communication supports.

## References:

1. Flores G., et al.: Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. 111(1): 6–14, 2003.
2. Elderkin-Thompson V., Silver R.C., Waitzkin H.: When nurses double as interpreters: A study of Spanish-speaking patients in a U.S. primary care setting. *Social Science and Medicine*. 52:1343–1358, 2001.
3. Hampers L.C., McNulty J.E.: Professional interpreters and bilingual physicians in a pediatric emergency department. *Archives of Pediatric Adolescent Medicine*. 156 (11):1108–1113, 2002.
4. Divi C., Koss R.G., Schmaltz S.P., Loeb J.M.: Language proficiency and adverse events in U.S. hospitals: A pilot study. *Int J Qual Health Care* 19(2):60–67, Apr. 2007.
5. Bartlett G., et al.: Impact of patient communication problems on the risk of preventable adverse events in acute care settings. *CMAJ* 178(12):1555–1562, Jun. 3, 2008.

## Recommendations from the Roadmap

- Address patient communication needs.
- Integrate unique patient needs into new or existing hospital policies.
- Develop a system to provide language access services.
- Address the communication needs of patients with sensory or communication impairments.
- Support the patient's ability to understand and act on health information.
- Integrate health literacy strategies into patient discussions and materials.







## Appendix D

# LAWS AND REGULATIONS

Virtually all hospitals nationwide—and most health care providers—are subject to federal civil rights laws. These laws address requirements for language access services to ensure meaningful access for limited English proficient (LEP) individuals and effective communication services for deaf or hard of hearing persons. It is critical for hospitals to be aware of these laws and how state and federal agencies enforce them.

The U.S. Department of Justice (DOJ) and the U.S. Department of Health and Human Services (HHS) Office for Civil Rights investigate federal civil rights complaints against hospitals. Investigations can consume hundreds of hours of time, and hospitals may spend precious resources responding to data requests and participating in on-site visits. The investigations may also require multiple interviews and involve protracted settlement negotiations. Violations can result in money damages.

A hospital that implements policies and procedures consistent with federal civil rights laws will not only meet patients' needs but also avoid potential investigations and subsequent liability for noncompliance. This appendix provides basic background information on these laws and highlights recent settlements negotiated by both federal agencies that investigate federal civil rights complaints. It also presents some key technical assistance guidance that can help hospitals comply with the law.

This appendix includes discussion on the following laws and regulations:

- Title VI of the Civil Rights Act of 1964
- Section 504 of the Rehabilitation Act of 1973
- The Americans with Disabilities Act (ADA)
- Title XVIII of the Social Security Act
- Hill-Burton Act
- Age Discrimination Act of 1975
- Section 542 of the Public Health Service Act

### **Title VI of the Civil Rights Act of 1964: Language Access for LEP Persons**

Title VI is a civil rights law in the Civil Rights Act of 1964 prohibiting discrimination in a variety of situations and circumstances. It ensures that federal money does not support programs or activities that discriminate on the basis of race, color, or national origin: Specifically, Title VI says:

No person in the United States shall, on 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 [1].

The failure to ensure that LEP persons can effectively participate in, or benefit from, federally-assisted programs and activities may violate prohibitions against national origin discrimination. Specifically, if a recipient\* of federal financial assistance from HHS—such as a hospital that participates in the Medicare program—fails to take reasonable steps to provide LEP persons with meaningful opportunity to participate in HHS-funded programs, it may constitute a violation of Title VI regulations.

Title VI regulations prohibit conduct that has a discriminatory effect on the basis of race, color, or national origin. Policies and practices that adversely effect people with limited proficiency in English may have a discriminatory effect on the basis of national origin. Thus, hospitals that receive federal funding must take reasonable steps to grant people with LEP meaningful access to their programs and services. Title VI applies to any hospital that receives federal funds, including Medicare, Medicaid, Children's Health Insurance Program (CHIP), research grants from the Centers for Disease Control and Prevention (CDC) or National Institutes of Health

\* Appendix D has been tailored to speak directly to "hospitals" in lieu of using the word "recipients," since the vast majority of hospitals participate in the Medicare program (and are covered with respect to Title III of the ADA regardless of Medicare participation).

(NIH), or other federal funds. Title VI protection generally extends to all programs and activities of any health care entity receiving federal financial assistance, whether or not the particular program at issue has itself received those funds [2].

According to the HHS implementing regulation for Title VI, a hospital that receives federal financial assistance may not, based on race, color, or national origin:[3]

- Deny services, financial aid, or other benefits provided as a part of health or human service programs
- Provide a different service, financial aid or other benefit, or provide them in a different manner from those provided to others under the program
- Segregate or separately treat individuals in any matter related to the receipt of any service, financial aid, or other benefit

### Revised HHS LEP Guidance—Effective Practices for Title VI Compliance

The Revised HHS LEP Guidance provides an analytical framework that hospitals may use to determine how to best comply with obligations to provide meaningful access for individuals who are limited English proficient to the benefits, services, information, and other important portions of their programs and activities [4].\* While designed to be a flexible and fact-dependent standard, the starting point for an individualized LEP assessment should balance the following four factors:

1. The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee
2. The frequency with which LEP individuals come in contact with the program
3. The nature and importance of the program, activity, or service provided by the program to people's lives
4. The resources available to the hospital and costs

The Revised HHS LEP Guidance seeks to suggest a balance between allowing access by LEP persons to critical services while not imposing undue burdens on small business, small local governments, or small nonprofits.

Highlighted in the next section are several tips and tools contained in the Revised HHS LEP Guidance, including how to

develop an effective LEP implementation plan, interpreter competency, and translation of written documents.

### Typical Elements in Effective LEP Implementation Plans

While an LEP implementation plan is not required, should a hospital decide to develop such a plan, the Revised HHS LEP Guidance document provides five elements for making the plan most effective:†

1. Identify LEP individuals who need language assistance.
 

The first two factors in the analytical framework require the hospital to assess the number or proportion of LEP individuals eligible to be served or encountered and the frequency of encounters. Accordingly, this step requires a hospital to understand how it will identify LEP persons with whom it has contact and/or could have contact.
2. Describe language assistance measures. Include information about the ways in which the hospital will provide language assistance. For instance, hospitals may want to include information on at least the following items:
  - Types of language services available
  - How staff can obtain those services
  - How staff should respond to LEP callers
  - How staff should respond to written communications from LEP persons
  - How staff should respond to LEP individuals who have in-person contact with hospital staff
  - How to ensure competency of interpreters and translation services
3. Train staff. Construct a process for identifying staff who need LEP plan training, design a plan for training them, and determine the desired outcomes of the training. An effective LEP plan may include training all staff on LEP policies and procedures and staff who have contact with the public to work effectively with in-person and telephone interpreters.
4. Provide notice to LEP persons. Describe the process by which the hospital will notify LEP persons the hospital serves or, to the extent that a service area exists, LEP persons that reside in its service area and are eligible for services of the LEP services that are available.
5. Monitor and update the LEP plan. Identify a process for the hospital to monitor its implementation of the LEP plan and

\* Note that the HHS LEP policy guidance is not a regulation but rather a guide, and that portions excerpted in this section are not reproduced in their entirety. The entire document is available at <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>; a summary of the guidance is available at <http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html>. The Revised HHS LEP Guidance "Q&A" can be found at <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/finalproposed.html>.

† See full discussion at pp. 17–19 of the HHS LEP Guidance.

for updating the plan as necessary. For example, changes in demographics, types of services, or other needs may require annual reevaluation of an LEP plan or the hospital may develop a schedule for determining, on an ongoing basis, whether new documents, programs, services, and activities need to be made accessible for LEP individuals.

### Interpreter Competency

Hospitals should take reasonable steps to assess whether interpreters demonstrate proficiency in the ability to communicate information accurately in both English and in the other language. To the extent necessary for communication between the hospital or its staff and the LEP person, interpreters should have knowledge in both languages of any specialized terms or concepts peculiar to the hospital's program or activity. Hospitals should take reasonable steps to assess whether interpreters understand and follow confidentiality and impartiality rules to the same extent as the hospital employee for whom they are interpreting and/or to the extent their position requires, and adhere to their role as interpreters without deviating into other roles—such as counselor or legal advisor—where such deviation would be inappropriate.\*

### Document Translation†

After applying the four-factor analysis, a hospital may determine that an effective LEP plan for its particular program or activity will include the translation of vital written materials into the language of each frequently encountered LEP group eligible to be served and/or likely to be affected by the hospital's program. Whether or not a document (or the information it solicits) is "vital" may depend on the importance of the program, information, encounter, or service involved, and the consequence to the LEP person if the information in question is not provided accurately or in a timely manner.

Vital written materials could include the following examples:

- Informed consent
- Complaint forms
- Intake forms that may have clinical consequences
- Notices of eligibility criteria for, rights in, denial or loss of, or decreases in benefits or services
- Notices advising LEP persons of free language assistance programs or services
- Applications to participate in a hospital program or activity or to receive hospital benefits or services

Nonvital written materials could include the following examples:

- Menus
- Large documents such as enrollment handbooks (although vital information contained in large documents may need to be translated)
- Third-party documents, forms, or pamphlets distributed as a public service
- General information about the program intended for informational purposes only

The languages spoken by the LEP individuals with whom the hospital has contact determine the languages into which vital documents should be translated. A distinction should be made, however, between languages that are frequently encountered by a hospital and less commonly encountered languages. The Revised HHS LEP Guidance provides tips regarding how to determine into which languages documents should be translated.

HHS identifies "safe harbor" actions that give hospitals greater certainty that they comply with their Title VI obligations to provide written translations in languages other than English. HHS considers the following actions strong evidence of compliance with the hospital's written-translation obligations:

- The hospital provides written translations of vital documents for each eligible LEP language group that constitutes 5% or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally
- If there are fewer than 50 persons in a language group that reaches the 5% trigger, the hospital does not translate vital written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials, free of cost

### Complaint Investigation and Resolution

HHS will investigate a complaint, report, or other information that alleges or indicates possible noncompliance with Title VI or its regulations. HHS informs the hospital, in writing, if the investigation results in a finding of compliance, including the basis for the determination. However, if a full investigation results in a finding of noncompliance, HHS sends a Letter of Findings that

\* See full discussion at pp. 10–12 of the HHS LEP Guidance.

† See full discussion at pp. 14–16 of the HHS LEP Guidance.

outlines areas of noncompliance and the corrective steps that the hospital must take. HHS will attempt to secure the hospital's voluntary compliance through informal means.

If HHS cannot resolve the matter informally, it will secure compliance through (a) the suspension or termination of Federal assistance after the recipient has been given an opportunity for an administrative hearing, (b) referral to the DOJ for injunctive relief or other enforcement proceedings, or (c) any other means authorized by law.

HHS engages hospitals in voluntary compliance efforts and provides technical assistance at all stages of an investigation. During these efforts, HHS proposes reasonable timetables for achieving compliance and consults with and helps hospitals explore cost-effective ways of coming into compliance. In determining a hospital's compliance with the Title VI regulations, HHS's primary concern is to make sure that the hospital's policies and procedures provide meaningful access for LEP persons to the hospital's programs and activities.

Reviewing summaries of recent HHS Title VI settlement agreements can give a hospital greater insight into the types of activities that may or may not be considered compliant, enforcement activities, and results. The HHS Office for Civil Rights offers cases examples online that include settlements with hospitals and pharmaceutical benefit companies as well as state and country departments of social services. The experiences of the following organizations can be found online:\*

- The Office for Civil Rights conducted an investigation and subsequent compliance review concerning a complaint alleging that the Hawaii Department of Human Services (HDHS) denied an interpreter to an individual with limited English proficiency. HDHS signed, in August 2008, a voluntary resolution agreement acknowledging that LEP individuals need language assistance services to access and fully participate in programs and activities operated by HDHS. Serving a population of more than 1.2 million individuals, HDHS provides benefits and services throughout the state of Hawaii through its 4 divisions and 88 local offices located on 5 islands, including Temporary Assistance for Needy Families (TANF), child and adult protective services, medical programs for low-income families including Medicaid, and home and community-based services. Under the agreement, HDHS will, among other things,

notify individuals with limited English proficiency of the availability of free language assistance, provide interpreters upon request, translate vital program documents, and train HDHS staff on policies and procedures for communicating with and serving persons with limited English proficiency. HDHS agreed to submit semi-annual progress reports to the Office for Civil Rights for a period of three years.

- In June 2009, Medco, the nation's largest pharmacy benefit manager, dispensing more than one hundred million prescriptions a year through pharmacy, home delivery and mail order operations, took steps to implement a multi-faceted plan to improve services to individuals with limited English proficiency following an investigation by the Office for Civil Rights of a complaint filed on behalf of a Spanish-speaking member. Medco will expand its pool of bilingual customer service representatives who speak Spanish and redesign its referral system to more quickly link Spanish-speaking members to bilingual staff. Medco will continue to use a telephonic interpreter service available for more than 150 other languages to improve communication with other LEP individuals and will make improvements to its internal computer systems to more quickly flag language preference and allow important written communications and outbound telephone calls to be made in a member's primary language. Medco has also committed to developing an extensive evaluation process with respect to interpreter competency.

## **Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act: Effective Communication for People Who Are Deaf/Hard of Hearing**

With respect to language access for people who are deaf or hard of hearing, the vast majority of hospitals are subject to two different federal laws enforced by two different agencies (the DOJ and the HHS Office for Civil Rights) with respect to disability discrimination issues. Fortunately, the standards for effective communication under both laws are nearly identical.

Section 504 prohibits discrimination against otherwise qualified people with disabilities under any program or activity that receives federal financial assistance [5]. Similar to Title VI,

\* See <http://www.hhs.gov/ocr/civilrights/activities/examples/LEP/complaintcompliance.html>.

hospitals that receive federal funds (including Medicare, Medicaid, CHIP, or grants from CDC or NIH) may not discriminate against people with disabilities, including people who are deaf or hard of hearing.

Hospitals are also covered by the ADA. Title III applies to “public accommodations,” which by definition includes hospitals. Title II of the ADA covers public hospitals—that is, those operated by state and local governments—as programs of public entities.

Under both Section 504 and the ADA, hospitals must provide, at no additional cost, auxiliary aids to individuals with disabilities when necessary to ensure effective communication with individuals who are deaf or hard of hearing or who have vision or speech impairments. A hospital does not need to provide such services if doing so would result in a fundamental alteration of the offered services or place an undue burden on the hospital. Auxiliary aids include such services or devices as qualified interpreters, assistive listening headsets, television captioning and decoders, telecommunications devices for the deaf (TDDs), videotext displays, readers, taped texts, Braille materials, and large print materials [6].

### ADA Business Brief: DOJ Assistance for Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings

The legal standard under Section 504 and the ADA for providing communication assistance to people who are deaf or hard of hearing in hospital settings is virtually the same. As such, the DOJ’s ADA Business Brief *Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings* provides a sensible and very user-friendly aid to compliance for hospitals under either legal standard [7]. It serves as an excellent educational handout for providers, clinicians, and patients.

Hospitals must provide effective means of communication for patients, family members, and hospital visitors who are deaf or hard of hearing. The ADA Business Brief plainly states that all hospital programs and services, such as emergency room care, inpatient and outpatient services, surgery, clinics, educational classes, and cafeteria and gift shop services, are covered by the ADA. Wherever patients, their family members, companions, or members of the public are interacting with hospital staff, the hospital is obligated to provide effective communication.

The ADA Business Brief draws useful contrasts between types of communication to help in understanding when a hospital



### Helpful Tip: Guidance on Communicating with People Who Are Deaf or Hard of Hearing

An interpreter may be required for effective communication in the following situations:

- Discussing a patient’s symptoms and medical condition, medications, and medical history
- Explaining and describing medical conditions, tests, treatment options, medications, and surgery or other procedures
- Providing a diagnosis, prognosis, and recommendation for treatment
- Obtaining informed consent for treatment
- Communicating with a patient during treatment, testing procedures, and during physician’s rounds
- Providing instructions for medications, post-treatment activities, and follow-up treatments
- Providing mental health services, including group or individual therapy, or counseling for patients and family members
- Providing information about blood or organ donations
- Explaining living wills and powers of attorney
- Discussing complex billing or insurance matters
- Making educational presentations, such as birthing and new parent classes, nutrition and weight management counseling, and CPR and first aid training

**Source:** U.S. Department of Justice (DOJ), Civil Rights Division, Disability Rights Section. ADA Business Brief: *Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings*. Washington, D.C.: DOJ Civil Rights Division, 2003. Available at <http://www.ada.gov/hospcombrscr.pdf>. Accessed March 3, 2010.

may be obligated to provide interpreters or other auxiliary aids and services. Take the following, for example:

- Exchanging written notes in response to a visitor’s inquiry about a patient’s room number or pointing to items for purchase in the gift shop or cafeteria will likely be effective communication for brief and relatively simple face-to-face conversations.
- Written forms or information sheets may provide effective communication in situations with little call for interactive communication, such as providing billing and insurance information or filling out admission forms and medical history inquiries.

- A qualified sign language interpreter or other interpreter may be necessary for more complicated and interactive communications, such as a patient–caregiver discussion of symptoms, a physician’s presentation of diagnosis and treatment options to patients or family members, or a group therapy session.

The ADA Business Brief also describes the legal standard for a “qualified” interpreter in the hospital setting: an interpreter who can interpret competently, accurately, and impartially; is familiar with any specialized vocabulary used; and can interpret medical terms and concepts. The brief makes clear that hospital personnel who have a limited familiarity with sign language should interpret only in emergency situations for a brief time until a qualified interpreter can be present.

The ADA Business Brief also explicitly cautions against the inappropriate use of family members or other companions to interpret for a person who is deaf or hard of hearing in a medical emergency because the emotional situation may affect family members’ ability to interpret accurately. Hospitals should arrange to have qualified interpreters readily available on a scheduled basis and on an unscheduled basis with minimal delay, including on-call arrangements for after-hours emergencies. Larger facilities may choose to have interpreters on staff.

Patients or members of the public may need additional aids and services, such as note takers, captioned videos, or assistive listening systems, for effective communication during training or other educational services. Hospitals should develop protocols and provide training to make sure staff know how to obtain interpreter services and other communication aids and services when needed by persons who are deaf or hard of hearing.

### **Settlements and Court Cases Involving Deaf or Hard-of-Hearing Persons in Hospital Settings**

Again, reviewing summaries of recent disability case and resolution settlement agreements can give a hospital greater insight into the types of activities that may or may not be considered compliant, enforcement activities, and results. The recent settlement negotiated by the HHS Office for Civil Rights with the University of Utah Hospitals & Clinics

(UUHC) features provisions typical in agreements negotiated by the HHS Office for Civil Rights. UUHC provides care for residents of Utah and five surrounding states and see more than 850,000 patients per year. As a result of a 2009 agreement with the HHS Office for Civil Rights, patients with hearing, vision, and speech disabilities will be screened and provided with auxiliary aids and services. Further, the Utah system will develop new policies and procedures; improved notices to patients of available auxiliary aids and services; comprehensive records to assure ongoing provision of appropriate aids and services; and extensive training of personnel.\* The experiences of the following organizations can also be found online:†

- Scottsdale Healthcare–Osborn (SHO). The HHS Office for Civil Rights secured a signed Resolution Agreement that resolves a disability discrimination complaint against SHO, a 337-bed hospital and trauma center, serving 150,000 patients each year in Scottsdale, Arizona. The complainant, who has severe hearing loss, reported that she was denied a sign language interpreter when treated in the SHO emergency room and intensive care unit. After receiving her complaint and investigating it, the Office for Civil Rights was able to resolve the matter with SHO. SHO agreed to do the following:
  - Affirm its compliance with Section 504 of the Rehabilitation Act of 1973
  - Issue and post revised policies to make sure it provides appropriate auxiliary aids, including sign language interpreters or video interpretation services, to deaf or hard of hearing patients or companions within a two-hour time period
  - Develop procedures to assess the need of patients or companions for a sign language interpreter
  - Train hospital personnel and physicians on its revised policies and procedures to ensure effective communication
  - Place TTY (telephone typewriter) lines throughout its facility
  - Maintain a centralized telecommunication number 24-hours per day, 7-days per week for sign language interpreter requests
  - Provide regular compliance reports to the Office for Civil Rights.

\* See the University of Utah Hospitals & Clinics settlement agreement at <http://www.hhs.gov/ocr/civilrights/activities/examples/Disability/uuhcra.pdf>.

† See summaries of other recent HHS Office for Civil Rights settlements involving deaf and hard of hearing persons at <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/hospitalcommunication/ecdisabilitycaseexamples.html>.

- Catskill Regional Medical Center (CRMC). The complainant, who is deaf, reported that staff failed to provide her with a sign language interpreter on several occasions at CRMC, a 162-bed hospital serving 56,000 patients each year in Sullivan County, New York which has an emergency response helicopter and a trauma center. After a subsequent investigation by the Office for Civil Rights, CRMC signed an OCR Resolution Agreement to resolve the matter and agreed to do the following:
  - Prohibit surcharges on auxiliary aids and services, including sign language interpreters, video interpretation services, note takers, assistive listening devices, and computer-assisted real-time transcription
  - Affirm its compliance with Section 504 of the Rehabilitation Act of 1973
  - Designate a Section 504 Coordinator and develop a Section 504 grievance procedure
  - Issue and post revised policies to make sure it provides appropriate auxiliary aids, including sign language interpreters or video interpretation services, to deaf or hard of hearing patients or companions within set time periods
  - develop procedures to assess the sign language interpreter needs of patients or companions
  - Train CRMC personnel on its revised policies and procedures to ensure effective communication
  - Provide regular compliance reports to the Office for Civil Rights.
- Florida Department of Children and Families (DCF). In its complaint investigation, the Office for Civil Rights found that the state violated Section 504 of the Rehabilitation Act of 1973 and Title II of the ADA when it failed to provide interpreters to deaf persons in critical situations, such as during child protective services investigations and during treatment in state mental health facilities. Under the agreement, Florida DCF will make a wide spectrum of health and human services programs available to an estimated total state population of 3 million deaf or hard of hearing residents. The agreement requires the state to take a number of unique (and potentially costly) corrective actions, including the following:
  - Hiring an independent consultant to oversee implementation of the settlement's terms
  - Convening an advisory committee in partnership with the Florida Coordinating Council for the Deaf and Hard of Hearing
  - Undertaking a comprehensive self-assessment that re-

quires surveys of staff and of disability advocacy organizations regarding gaps in service experienced by deaf and hard-of-hearing individuals

- Establishing an interpreter quality assessment and certification program

Under some circumstances, the federal agencies' agreements and decrees have provided for compensatory damages for the lack of an interpreter or other aid for a patient's family members who are deaf or hard of hearing. In 2003, the DOJ filed a lawsuit in 2003 against Parkway Hospital, a private hospital in Queens, New York, for allegedly failing to provide a qualified sign language interpreter for an elderly deaf patient or her deaf husband during the woman's extended hospitalization. In addition, DOJ alleged the hospital violated the ADA by imposing communication responsibilities on the couple's grown children, who were expected to act as conduits for information between the family and hospital staff. Because of these failures, the patient's husband allegedly was unable to obtain complete information about his wife's medical diagnosis, treatment, and prognosis. Under the ruling in *United States v. Parkway Hospital, Inc.* [8], the hospital was required to pay \$125,000 in compensatory damages to the family and to adopt sign language interpreting policies and procedures intended to ensure effective communication for deaf patients and their family members [9].

Settlements have also addressed standards for video interpreting services. Enhanced and emerging technologies may allow health care providers to obtain qualified interpreters more quickly, economically, and efficiently 24 hours a day. Video interpreting services allow a qualified sign language interpreter to appear via video from a remote location on a television-like screen. A hospital opting for this approach must ensure that the appropriate hardware and software are in place to support the system and that staff understand how to operate and maintain the equipment [9]. If a hospital purports to utilize video interpreting services but does not provide the necessary administrative and operational support to make the system work, a patient with a hearing disability is denied his or her right to fully participate in health care decisions and family members are shut out from communicating with the hospital about their loved one.

In 2006, the DOJ intervened in a private lawsuit brought by seven deaf individuals against Laurel Regional Hospital alleging a failure to provide either in the emergency department or

during hospitalizations appropriate auxiliary aids and services necessary to ensure effective communication for deaf patients or deaf family members, including qualified interpreters.\* The Maryland hospital had an older system of video interpreting services available that did not perform well, if at all. The suit alleged that hospital staff had difficulty setting up and operating the system, the picture was at times too blurry for a patient to clearly distinguish the arms and hands of the video interpreter, and the video camera could not be adjusted for prone patients so that the interpreter and the patient could clearly see each other's hands, arms, and heads. In addition, the case alleged that the hospital failed to provide an interpreter for a deaf patient during hospitalization. The hospital allegedly did not attempt to communicate with the deaf patient in any way, but rather forced her hearing mother, who did not know sign language, to function as a relay person, consecutively exchanging simplistic messages between her adult daughter and the hospital staff regarding her daughter's condition and treatment.

*Gillespie v. Dimensions Health Corp., d/b/a Laurel Regional Hospital* [10] was resolved through a comprehensive consent decree which included detailed provisions for the implementation and administration of a program to ensure effective communication with persons with hearing disabilities. The consent decree required the hospital to continue to provide both on-site interpreters and interpreters appearing through video interpreting services where necessary for effective communication; to provide other auxiliary aids and services as necessary; to modify medical and intake forms to make sure that once a deaf or hard-of-hearing patient or family member enters the hospital, the hospital makes a communication assessment and, if necessary, a reassessment of the patient or family member; to maintain a complaint resolution/grievance procedure regarding the provision of auxiliary aids and services; and to train hospital personnel to accommodate the communication needs and preferences of deaf or hard-of-hearing patients and family members. In addition, DOJ required Laurel Hospital to satisfy specified performance standards for its video interpreting services regarding the quality and clarity of the televised video and

audio, regardless of the body position of the patient, and to train hospital staff to quickly and easily set up and operate the system. DOJ also made clear that, except in very limited instances, medical providers should not ask family members or other representatives to interpret for a person who is deaf or hard of hearing because of potential emotional involvement, considerations of confidentiality, and limited interpreting skills.

In 2004, the DOJ settled a lawsuit alleging that Fairview Health Services failed to provide qualified sign language interpreters and services to deaf patients in *United States v. Fairview Health Services*\* [11]. Under the agreement, Fairview agreed to hire and make available one or more qualified sign language interpreters 24 hours a day, seven days a week, to provide effective communication at each of its five hospitals in Minnesota, and to pay \$188,000 in damages to four complainants and \$20,000 in civil penalties. Fairview also agreed to rewrite its hospital policy and procedures affecting patients with disabilities, develop patient and visitor information and notices in forms that are accessible to deaf and hard-of-hearing patients, and conduct comprehensive training of hospital personnel.†

## Section 504 of the Rehabilitation Act of 1973 and the ADA: Other Types of Prohibited Discrimination

Federal law prohibiting discrimination on the basis of disability addresses a broad range of issues beyond effective communication. Section 504 regulates how hospitals that receive federal funding provide aid, benefit, or service, either directly or through contractual, licensing, or other arrangements, to individuals with disabilities. Hospitals are also subject to similar requirements under the ADA. Title III of the ADA applies to "public accommodations," which by definition includes hospitals. Title II of the ADA covers public hospitals -- that is, those operated by state and local governments -- as programs of public entities.

Such hospitals cannot take the following actions against qualified individuals with a disability, unless to do so would result

\* This case description is from the DOJ Access for All: Five Years of Progress report, available at <http://www.ada.gov/5yearadarpt/fiveyearada1.htm>.

† The allegations in the Laurel Regional Hospital case illustrate the problems that can result when a hospital fails to take the necessary steps, through a video interpreting service or otherwise, to ensure effective communication. Hospitals often mistakenly use family members as interpreters in non-emergency situations and inappropriately rely on lip-reading for complicated medical discussions. In the Laurel Regional Hospital case, one complainant complained to the DOJ that her mother was often unable to communicate to her what hospital personnel had said, and that because her mother does not know sign language, the patient was forced, often unsuccessfully, to try to read her mother's lips. The patient said she felt frustrated, angry, and ignored by the hospital.

‡ Similar agreements have been reached between DOJ and Greater Southeast Community Hospital in Washington, D.C., St. Francis Healthcare in Wilmington, Delaware, and South Florida Baptist Hospital in Plant City, Florida.



in an undue burden or fundamental alteration in a program or activity [12]:

- Deny the opportunity to participate in or benefit from the aid, benefit, or service
- Afford an opportunity to participate in or benefit that is not equal to that afforded others
- Provide an aid, benefit, or service that is not as effective as that provided to others
- Provide different or separate aid, benefit, or service unless such action is necessary to provide aid, benefit, or service that is as effective as those provided to others
- Aid or perpetuate discrimination by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap
- Deny the opportunity to participate as a member of planning or advisory boards
- Otherwise limit the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service

Similarly, under federal law, hospitals cannot take any of the following actions toward qualified individuals with disabilities, on the basis of the disability, unless to do so would result in an undue burden or fundamental alteration in a program or activity [6]:

- Establish or apply eligibility criteria for receipt of services or participation in programs or activities that screen out or tend to screen out individuals with disabilities, unless such criteria are necessary to meet the objectives of the program
- Provide separate or different benefits, services, or programs unless it is necessary to ensure that the benefits and services are equally effective
- Refuse to allow a person with a disability to participate in, or benefit from, their services, programs or activities

Further, these covered entities must, unless to do so would result in an undue burden or fundamental alteration in a program or activity, do the following [6]:

- Provide services and programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
- Make reasonable modifications in policies, practices, and procedures to avoid discrimination on the basis of disability.
- Make buildings accessible.
- Provide auxiliary aids, at no additional cost, where necessary

to ensure effective communication with individuals with hearing, vision, or speech impairments.\*

Examples of discrimination on the basis of disability would include failing to make reasonable modifications, provide auxiliary aids and services, or remove architectural barriers. Such failures effectively prevent people with disabilities from enjoying the goods and services offered in a public space. This means that hospitals must modify policies, practices, and procedures, when necessary, to allow people with disabilities to gain full and equal access to services, unless a requested modification constitutes a fundamental alteration of the health care service itself or an undue burden. For example, if a hospital had a policy of not providing assistance to patients with undressing, it would have to modify that policy if someone with mobility impairment required such assistance to receive a proper examination. Hospitals must also provide auxiliary aids and services such as sign language interpreters, assistive listening devices, and written medical information in such alternative formats as Braille and large print, unless the hospital can establish that doing so would fundamentally alter the nature of the health care service or constitute an undue burden. Finally, hospitals must remove architectural barriers, such as steps, narrow doorways, and inaccessible toilets, in existing facilities if doing so is “readily achievable.” New construction hospitals or those that undertake alterations to existing facilities must make sure that the new construction or alteration meets the higher standard of being readily accessible [13].

## **Section 504 of the Rehabilitation Act of 1973 and the ADA: Accessible Medical Facilities and Equipment**

Disability discrimination issues may arise across a broad range of situations in the hospital setting, including the accessibility of medical facilities and equipment. Both the HHS Office for Civil Rights and the DOJ have negotiated settlement agreements requiring medical facilities to make physical accessibility improvements. The Washington Hospital Center agreement presents one of the most comprehensive. Under the terms of the agreement, Washington Hospital Center agreed to do the following:

- Create a minimum of 35 fully accessible patient rooms, with each including an accessible toilet room and an accessible shower (or access to one)

\* Auxiliary aids include such services or devices as: qualified interpreters, assistive listening headsets, television captioning and decoders, telecommunications devices for the deaf (TDDs), videotext displays, readers, taped texts, Braille materials, and large print materials.

- Purchase adjustable-height beds for all of its accessible inpatient rooms
- Make sure that each department has at least one accessible examination table that lowers to 17 to 19 inches from the floor to enable individuals who use wheelchairs to transfer to the examination equipment
- Survey all of the equipment in the hospital and purchase needed accessible equipment to ensure that individuals with disabilities receive equal access to medical services, including an accessible examination table or chair in each hospital department that utilizes them
- Implement a barrier removal plan
- Update hospital policies and train staff to address the needs of individuals with disabilities

Similarly, both agencies have addressed issues involving inaccessible medical equipment. For example, the DOJ investigated a case involving Exodus Women's Center, an obstetrics and gynecology center which provided services to women in four different locations in Florida [9]. The investigation stemmed from a complaint filed by a woman who uses a wheelchair due to a neurological condition. The complainant alleged that, when she arrived for her appointment, staff told her that she needed to bring someone to assist her onto the examination table and refused to help her transfer. She left without receiving an important medical examination. Under the terms of the agreement with the DOJ, the center agreed to do the following:

- Purchase an adjustable-height examination table for one office within two months of the agreement and a second table for another office within twelve months
- Ask patients, when scheduling an appointment, if they will need any assistance, modification of policy, or auxiliary aid or service during the exam due to a disability
- Conduct ADA training for all of its medical and administrative staff, including teaching transferring techniques and providing sensitivity training on interacting with individuals with disabilities

A similar case alleges failure to provide obstetrics and gynecology treatment against the Obstetrics and Gynecology Clinic at Georgetown University Medical Center in Washington, D.C. [9]. The DOJ negotiated a settlement with Georgetown after it received a complaint by a woman who alleged that staff had failed to assist her with transferring from

her wheelchair to an examination table when the sole adjustable table was not working. Georgetown agreed to pay a civil penalty of \$10,000 and damages of \$15,000 to the complainant.

## Other Federal, State, and Local Laws

Hospitals should be aware of nondiscrimination provisions of other laws as they apply to hospital settings, including Title XVIII of the Social Security Act, the Hill-Burton Act, the Age Discrimination Act of 1975, Section 542 of the Public Health Service Act, and applicable state and local laws.

### Title XVIII of the Social Security Act: Compliance with Federal Civil Rights Laws

Hospitals should also be aware that any health care provider that wants to participate in the Medicare Part A program must obtain a civil rights clearance to be approved for funds from HHS under Title XVIII of the Social Security Act. Each year, the HHS Office for Civil Rights conducts up to 4,000 compliance reviews, depending on the number of provider applicants to the Medicare Program.

In each of these reviews, the office assesses, among other things, whether the provider has an adequate policy and procedure in place to ensure effective communication with LEP persons and persons who are deaf or hard of hearing. Following the review, it works with the provider to make sure effective policies, approved by the Office for Civil Rights, are in place by the time it completes the review. HHS OCR generally conducts around 2,000 such reviews annually, and achieves corrective action in up to 60% of the cases.

### Hill-Burton Act: Community Service Obligations

The Hill-Burton Act authorized assistance for construction and renovation of public and other nonprofit medical facilities [14, 15].\* The community service assurance requirement mandates that hospitals that receive Hill-Burton funds make services available to persons residing in the hospital's service area without discrimination on the basis of race, color, national origin, creed, or any other ground unrelated to the individual's need for the service or the availability of the needed service in the facility [16]. In addition, hospitals must report information prescribed by HHS to determine their compliance with the

\* While no new projects are funded under the Hill-Burton Act, the community service assurance requirement continues indefinitely for projects that received funds.

requirement to provide a designated level of uncompensated care to individuals unable to pay [17]. Many hospitals remain subject to Hill-Burton requirements even though funds are no longer distributed.\*

According to the HHS Office for Civil Rights, every Hill-Burton hospital must comply with the following basic requirements to fulfill the community service obligation [18]:

- Meet the right of persons residing in its service area to medical treatment without regard to race, color, national origin, or creed
- Participate in the Medicare and Medicaid programs unless they are ineligible to participate
- Make arrangements for reimbursement for services with principal state and local third-party payors that provide reimbursement that is not less than the actual cost of the services
- Post notices informing the public of its community service obligations in English, Spanish, and, if 10% or more of the households in the service area usually speak a language other than English or Spanish, that language as well
- Do not deny emergency services to any person residing in the hospital's service area on the grounds that the person is unable to pay for those services
- Do not adopt patient admissions policies that have the effect of excluding persons on grounds of race, color, national origin, creed or any other ground unrelated to the patient's need for the service or the availability of the needed service

### Age Discrimination Act of 1975

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs or activities receiving federal

financial assistance and applies to persons of all ages [19]. The act does not apply to employment or to certain exceptions that permit, under limited circumstances, use of age distinctions or factors other than age that may have a disproportionate effect on the basis of age. This could include age distinction contained in that part of a federal, state, or local statute or ordinance which provides any benefits or assistance to persons based on age, establishes criteria for participation in age-related terms, or describes intended beneficiaries or target groups in age-related terms [20].

### Section 542 of the Public Health Service Act: Substance Abusers

Section 542 of the Public Health Service Act prohibits discrimination in admission or treatment against substance abusers by hospitals receiving federal funds [21]. A hospital cannot discriminate against a drug or alcohol abuser or alcoholic who is suffering from a medical condition, because of the person's drug or alcohol abuse or alcoholism.

### State and Local Laws

Depending on your location, there may be state or local laws that prohibit discrimination or impose other requirements related to effective communication, culturally competent, and patient- and family-centered care. For example, many states have statutes or regulations requiring meaningful language access that are more comprehensive than federal law. Some states also require cultural competency training for health professionals [22].

### References:

1. 42 U.S.C. § 2000d; *See also* 45 C.F.R. § 80 App. A
2. 42 U.S.C. § 2000d-4a
3. Office for Civil Rights: *Fact Sheet: Your Rights under Title IV of the Civil Rights Act of 1964*. Washington, DC: U.S. Department of Health and Human Services, Office for Civil Rights, 2006. Available at <http://www.hhs.gov/oct/civilrights/resources/factsheets/yourrightsundertitleivofthecivilrightsact.pdf>. (Accessed March 3, 2010.)
4. Office for Civil Rights: *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons*. Washington, DC: U.S. Department of Health and Human Services, Office for Civil Rights, 2003. Available at <http://www.hhs.gov/oct/civilrights/resources/specialtopics/lep/policyguidancedocument.html>. Accessed March 2, 2010.
5. *Rehabilitation Act of 1973*, 29 U.S.C. § 794.

\* A list of facilities covered under Hill-Burton may be found at <http://www.hrsa.gov/HILLBURTON/hillburtonfacilities.htm>.

6. Office for Civil Rights: *Fact Sheet: Your Rights under Section 504 and the Americans with Disabilities Act*. Washington, DC: U.S. Department of Health and Human Services, Office for Civil Rights, 2006. Available at: <http://www.hhs.gov/ocr/civilrights/resources/factsheets/504ada.pdf>. (Accessed March 3, 2010.)
7. U.S. Department of Justice (DOJ), Civil Rights Division, Disability Rights Section. ADA Business Brief: *Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings*. Washington, D.C.: DOJ Civil Rights Division, 2003. Available at <http://www.ada.gov/hospcombrscr.pdf>. (Accessed March 3, 2010.)
8. *United States v. Parkway Hosp., Inc.*, No. 03-1565 (E.D.N.Y. Apr. 29, 2004). Available at <http://www.ada.gov/parkway.htm>. (Accessed April 20, 2010.)
9. U.S. Department of Justice Civil Rights Division: *Access for All: Five Years of Progress – A Report from the Department of Justice*. Washington, DC.: DOJ, 2006. Available at <http://www.ada.gov/5yearadarpt/fiveyearada1.html>. (Accessed April 20, 2010.)
10. *Gillespie v. Dimensions Health Corp., d/b/a Laurel Reg. Hosp.*, No. 05-73 (D. Md.). Available at <http://www.ada.gov/laurelco.htm>. (Accessed April 20, 2010.)
11. *United States v. Fairview Health Serv.*, No. 04-4955 (D. Minn. Dec. 8, 2004). Available at <http://www.ada.gov/fairview.htm>. (Accessed April 20, 2010.)
12. 45 C.F.R. § 84.4(b)(1)(i)–(iii)
13. National Council on Disability: *The Current State of Health Care for People with Disabilities*. Washington, DC: National Council on Disability, 2009. Available at <http://www.ncd.gov/newsroom/publications/2009/pdf/HealthCare.pdf>. (Accessed March 1, 2010.)
14. 42 U.S.C. § 291, *et seq*
15. 42 C.F.R. § 124.603
16. 42 U.S.C. § 300s-6; 42 C.F.R. § 124.9, 42 C.F.R. § 124.603
17. 42 C.F.R. §§ 124.501, 124.503, 124.509, 124.605.
18. Office for Civil Rights: *Fact Sheet: Your Rights under the Community Service Assurance Provision of the Hill-Burton Act*. Washington, DC: U.S. Department of Health and Human Services, Office for Civil Rights, 2006. Available at: <http://www.hhs.gov/ocr/civilrights/resources/factsheets/hillburton.pdf>. (Accessed March 3, 2010.)
19. 45 C.F.R. § 91.3
20. Office for Civil Rights: *Fact Sheet: Your Rights under the Age Discrimination Act of 1975*. Washington, DC: U.S. Department of Health and Human Services, Office for Civil Rights, 2001. Available at: <http://www.hhs.gov/ocr/age.html>. (Accessed April 20, 2010.)
21. 42 U.S.C. 290dd-1; 45 C.F.R. § 84.53
22. Perkins J., Youdelman M.: *Summary of State Law Requirements: Addressing Language Needs in Health Care*. Washington, DC: National Health Law Program, 2008. Available at <http://www.healthlaw.org/images/stories/issues/nhelp.lep.state.law.chart.final.0319.pdf>. (Accessed March 3, 2010.)



# Appendix E

## RESOURCE GUIDE

Appendix E contains many Web sites, toolkits, articles, and other information that can serve to inform the development of practices that best meet diverse patient needs, support quality and safety, and aid in compliance with law, regulation and accreditation standards. This is by no means an exhaustive list, and inclusion should not be considered an endorsement, as the authors have not undertaken any evaluation of these resources.

The resources in this appendix correspond to the five domains in Chapter 6: Organization Readiness and are divided into the following categories.

1. **Leadership Domain (page 77)**
  - Organization Assessment Using Frameworks, Tools, and Guidelines
2. **Data Collection and Use Domain (page 79)**
  - Collecting and Using Patient- and Community-Level Data for Service Planning
3. **Workforce Domain (page 80)**
  - Working with an Interpreter
  - Cultural Competency Training
  - Competencies for Interpreters and Translators
4. **Provision of Care, Treatment, and Services Domain (page 82)**
  - Improving Overall Patient–Provider Communication
  - Developing Language Access Services for Patients Who Speak a Language Other Than English
  - Translating Materials into Other Languages and Sources for Materials in Other Languages
  - Respecting, Understanding, and Addressing Cultural Beliefs
  - Addressing Religious and Spiritual Beliefs and Practices
  - Addressing the Needs of Patients with Disabilities
  - Addressing the Needs of Patients with Physical or Cognitive Communication Needs

- Addressing the Needs of Patients Who Are Blind or Have Low Vision
- Addressing the Needs of Patients Who Are Deaf or Hard of Hearing
- Addressing Health Literacy Needs
- Addressing the Needs of Lesbian, Gay, Bisexual, and Transgender Patients
- Providing Care at the End of Life
- Cultural Competency Materials for Specific Populations or Conditions

5. **Patient, Family, and Community Engagement Domain (page 89)**
  - Encouraging Patient and Family Engagement
  - Engaging the Community

Many areas overlap. To prevent duplication, we have tried to list items only once, under the section for which the resource would most likely be sought. The resources provided here are accurate as of May 2010.

### **Leadership Domain Organization Assessment Using Frameworks, Tools, and Guidelines**

1. *The Patient- and Family-Centered Care Organizational Self Assessment Tool* was developed by the Institute for Healthcare Improvement in conjunction with the National Initiative for Children's Healthcare Quality. It allows organizations to understand the range and breadth of patient- and family-centered care elements and to assess where they are regarding the leading edge of practice. Available at <http://www.ihl.org/IHI/Topics/PatientCenteredCare>.
2. The Department of Health and Human Services Office of Minority Health's *National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)* was developed with the input of a panel of experts. These 14 standards have been used by many hospitals and health care organizations to help guide their efforts to provide

- care in a manner that is responsive to patient's diverse needs and include. Four standards that reflect requirements for the provision of language service that can help organizations comply with Title VI of the Civil Rights Act. Available at <http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>.
3. The Joint Commission's *Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings* provides a comprehensive conceptual framework for understanding hospital systems for meeting patient's diverse cultural and linguistic needs. It contains recommendations for hospitals to improve their care and a protocol for conducting interviews with key administrative staff. Available at <http://www.jointcommission.org/patientsafety/hlc>.
  4. The Joint Commission's *One Size Doesn't Fit All: Meeting the Health Care Needs of Diverse Populations* report provides a framework and self-assessment tool for considering how your organization is meeting its patients' needs. Based on the premise of continuous assessment and monitoring for improvement, this guide also provides example practices from a study of 60 hospitals from across the country. Available at <http://www.jointcommission.org/patientsafety/hlc>.
  5. *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency* from the National Quality Forum outlines a comprehensive framework for measuring and reporting cultural competency. The report details 45 preferred practices for providing culturally competent care covering a range of issues, including communication, community engagement, and workforce training. Available at [http://www.qualityforum.org/Publications/2009/04/A\\_Comprehensive\\_Framework\\_and\\_PREFERRED\\_Practices\\_for\\_Measuring\\_and\\_Reporting\\_Cultural\\_Competency.aspx](http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_PREFERRED_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx).
  6. The American Medical Association's Ethical Force<sup>®</sup> program used its formal consensus process to develop a 360-degree organizational communication climate assessment toolkit (OCCAT), which was then validated in a 4-year national field test. The OCCAT surveys and other materials (including a Resource Guide for QI in each domain) are available online for free at <http://www.EthicalForce.org>. In addition, the Ethical Force Program's *Improving Communication—Improving Care* resource guide includes a comprehensive framework for considering how health care systems support effective communication including how to integrate these concepts into ongoing organization quality improvement efforts. Available at [http://www.ama-assn.org/ama1/pub/upload/mm/369/ef\\_imp\\_comm.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/369/ef_imp_comm.pdf).
  7. *Multicultural Health Best Practices Overview* from Diversity Rx provides information about best practices in delivering medical services to people from a wide variety of cultural and linguistic backgrounds. Available at <http://www.diversityrx.org/best>.
  8. National Public Health and Hospital Institute offers several resources including the following:
    - *Serving Diverse Communities in Hospitals and Health Systems: From the Experience of Public Hospitals and Health Systems* presents the applicable strategies from the various programs and approaches currently underway in National Association of Public Hospitals and Health Systems hospitals by presenting findings and lessons learned from case studies and a focus group and the development of a toolkit. Available at <http://www.naph.org/Publications/servingdiversecommunities.aspx>.
    - *Assuring Healthcare Equity: A HealthCare Equity Blueprint* outlines a framework for hospitals to address racial and ethnic disparities in health care. Available at <http://www.naph.org/Main-Menu-Category/Our-Work/Health-Care-Disparities/EquityBlueprint.aspx>.
  9. The American Organization of Nurse Executives' *Diversity in Healthcare Organizations Toolkit* helps health care leaders in supporting diversity efforts within their organizations. It includes sections on case studies, policy statements, educational materials, measurement standards and assessment tools, job descriptions and performance measures, evidence-based practice/research, recruitment and retention strategies, statements of organizational values, and other resources. The toolkit is an AONE members-only benefit and can be viewed in the resource section of the AONE Web site Available at <http://www.aone.org/aone/resource/gps.htm>.
  10. National Committee for Quality Assurance's *Multicultural Health Care: A Quality Improvement Guide* follows the steps of a basic quality improvement process: assessment, planning, implementation, and evaluation. Each chapter contains explanatory text, information on how to follow the process and resources and examples from a variety of settings. Available at <http://www.clashealth.org>.
  11. The Management Sciences for Health Web site *The Provider's Guide to Quality and Culture* is designed to help

- health care organizations provide high quality, culturally competent services to multi-ethnic populations. Available at <http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>.
12. Gay, Lesbian, Bisexual, and Transgender Health Access Project's *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients* is a framework that addresses personnel, client's rights, intake and assessment, service planning and delivery, confidentiality, and community outreach and health promotion. Available at <http://www.globthealth.org/CommunityStandardsofPractice.htm>.
  13. Human Rights Campaign Foundation's *Healthcare Equality Index: Creating a National Standard for Equal Treatment of Lesbian, Gay, Bisexual, and Transgender Patients and Their Families* includes recommended steps that health care institutions can take to improve care for lesbian, gay, bisexual, and transgender (LGBT) patients, particularly regarding advanced health care directives, parents' decision-making rights, and visitation policies. Available at [http://www.hrc.org/documents/Healthcare\\_Equality\\_Index\\_2009.pdf](http://www.hrc.org/documents/Healthcare_Equality_Index_2009.pdf).
  14. Planetree's *Patient-Centered Care Improvement Guide* is designed as a practical resource for health care organizations that contains best practices and practical implementation tools contributed by hospitals from across the United States. The self-assessment tool can help identify and prioritize opportunities for introducing patient-centered approaches into your organization. Available at <http://www.planetree.org/publications.html>.
  15. *The Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems* builds upon the Georgetown University Child Development Center's Continuum of Cultural Competency and is an innovative approach to assessing organization cultural competence. Available at <http://erc.msh.org/mainpage.cfm?file=9.1g.htm&module=provider&language=English>.
- primary language. Available at <http://www.hretdisparities.org>.
  2. The Disparities Solution Center's *Assuring Healthcare Quality: A HealthCare Equity Blueprint* offers a starting point for designing and implementing interventions to address racial and ethnic disparities in health care. Aspects of this Blueprint apply to numerous health care settings; however, the primary focus is on hospitals. Available at <http://www2.massgeneral.org/disparitiessolutions/resources.html>.
  3. The Robert Wood Johnson Foundation developed *Expecting Success: Excellence in Cardiac Care* to help hospitals measure the quality of cardiac treatment provided to patients. Participating hospitals tracked data based on patient race, ethnicity, and primary language against core measures of care for patients with heart failure or who had a heart attack. Available at <http://www.expectingsuccess.org>.
  4. The Institute of Medicine's *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* report includes recommendations for the standardized collection of race, ethnicity, and language data. The report recommends the collection of more granular ethnicity and language need according to national standards in addition to the Office of Management and Budget race and Hispanic ethnicity categories. Available at <http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx>.
  5. *For the Health Care CEO: Thinking about Language Access in Health Care* describes the importance of collecting community data in order to identify language needs. Available at <http://www.pgsi.com/Products/Resources/WhitePapers/WhitePaper1.aspx>.
  6. National Partnership for Action to End Health Disparities' *Strategic Framework for Improving Racial and Ethnic Minority Health and Eliminating Racial and Ethnic Health Disparities* serves as a guide for the systematic planning, implementation, and evaluation of efforts to achieve better results regarding health disparities. Leaders can utilize the Framework to determine the basis for the efforts to be funded and the desired outcomes. Available at <http://www.omhrc.gov/npa/templates/content.aspx?lvl=1&lvlid=13&cid=78>.
  7. Comprehensive Adult Student Assessment Systems provides an *Adult Literacy Estimates* tool which can be used to estimate English proficiency, race, and ethnicity demographics in a given area according to city, county, district, and state. Available at <http://www.casas.org/lit/litcode/search.cfm>.

## Data Collection and Use Domain

### Collecting and Using Patient- and Community-Level Data for Service Planning

1. The American Hospital Association's *Health Research and Educational Trust Disparities Toolkit* provides a step-by-step process for establishing a system to uniformly and systematically collect patient data by race, ethnicity, and

8. The Pfizer Clear Health Communication Initiative provides estimates of the percentage of patients who might have limited health literacy based on specific patient demographics. Available at <http://www.pfizerhealthliteracy.com/physicians-providers/prevalence-calculator.html>.
9. The Association for Community Health Improvement's *Community Health Assessment Toolkit* is a guide for planning, leading, and using community health assessments to improve the health of communities. Available at <http://www.assesstoolkit.org>.

## Workforce Domain

### Working with an Interpreter

1. Massachusetts Department of Public Health's *Best Practice Recommendations for Hospital-Based Interpreter Services* identifies and describes components of an optimal interpreter services program for hospitals. Available at [http://www.mass.gov/Eoehhs2/docs/dph/health\\_equity/best\\_practices.pdf](http://www.mass.gov/Eoehhs2/docs/dph/health_equity/best_practices.pdf).
2. *Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members* sponsored by the California Academy of Family Physicians provides information on identifying the patient population, different types of interpretation services, and model procedures and policies. Available at [http://www.calendow.org/uploadedFiles/language\\_access\\_issues.pdf](http://www.calendow.org/uploadedFiles/language_access_issues.pdf).
3. Minnesota Department of Human Services' "Tips for Working with Interpreters" helps to maximize effectiveness when a provider is working with an interpreter. Available at [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_051607](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_051607).
4. Association of American Medical College's *Guidelines for Use of Medical Interpreter Services* is a resource for medical students who need additional guidance regarding the use of a medical interpreter during interactions with limited English proficient (LEP) patients. Available at [http://www.aamc.org/students/medstudents/interpreter\\_guide.pdf](http://www.aamc.org/students/medstudents/interpreter_guide.pdf).
5. Rush University Medical Center's *Communicating Through Health Care Interpreters* offers a series of online courses to train doctors on how to work with professional interpreters, how to guide an untrained interpreter, and how to work with a telephone interpreter. Available at <http://www.vlh.com>.
6. Health Care Interpreter Network and Kaiser Permanente's *Qualified Interpreting for Quality Health Care: A Training*

*Video for Clinical Staff on How to Work with Interpreters* covers topics such as the importance of using a qualified interpreters, key protocols for language interpreting including confidentiality and first-person interpreting, cultural considerations, and tips for using remote interpreters (telephonic and video). Requests for copies should be sent to: [infor@hcin.org](mailto:infor@hcin.org).

7. American Speech–Language–Hearing Association's Web site has "Tips for Working with an Interpreter," including selecting an interpreter and things to be aware of before, during, and after a session using an interpreter. Available at <http://www.asha.org/practice/multicultural/issues/interpret.htm>.

### Cultural Competency Training

1. The California Endowment offers several resources including the following:
  - *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals* provides guidance on content, training methods and modalities, evaluation, and qualifications of teachers and trainers. Available at [http://www.calendow.org/uploadedFiles/principles\\_standards\\_cultural\\_competence.pdf](http://www.calendow.org/uploadedFiles/principles_standards_cultural_competence.pdf).
  - *Resources in Cultural Competence Education for Health Care Professionals* is a compilation of guidebooks, guidelines, manuals, articles, reports, videos, journals, and Web sites designed to help health care professionals to provide culturally appropriate education. Available at [http://www.calendow.org/uploadedFiles/resources\\_in\\_cultural\\_competence.pdf](http://www.calendow.org/uploadedFiles/resources_in_cultural_competence.pdf).
  - *The Multicultural Health Series* is a collection of 10 video case studies and training materials designed to educate providers about the meaning and importance of cultural competence in health care. Available at [http://www.calendow.org/uploadedFiles/multicultural\\_health\\_series.pdf](http://www.calendow.org/uploadedFiles/multicultural_health_series.pdf).
2. PRIME's continuing medical education (CME) online activity *Best Practices to Achieve Cultural Competence in Health Care* for physicians, nurses and nurse practitioners, and pharmacists focuses on increasing awareness of cultural and linguistic barriers that can occur between health care providers and patients of diverse backgrounds and enables providers to overcome these barriers to provide culturally competent care. Available at [http://primeinc.org/cme/online/178/Best\\_Practices\\_to\\_Achieve\\_Cultural\\_Competence\\_in\\_Health\\_Care](http://primeinc.org/cme/online/178/Best_Practices_to_Achieve_Cultural_Competence_in_Health_Care).



3. HealthCare Chaplaincy's two publications *A Dictionary of Patients' Spiritual & Cultural Values for Health Care Professionals* and *Cultural and Spiritual Sensitivity—A Learning Module for Health Care Professionals* provide cultural, religious, and spiritual guides, self-assessment tools, and tips for cultural, religious, and spiritual sensitivity. Available at <http://www.healthcarechaplaincy.org/chaplaincy-pastoral-care-management/improve-your-patient-care-through-cultural-competency.html>.
4. The American Medical Association's online CME programs on cultural competence and health care disparities. Available at <http://www.ama-assn.org/ama/pub/education-careers/continuing-medical-education/cme-credit-offerings.shtml>.
5. Fanlight Production has several films and training videos focusing on cross-cultural care; how race, ethnicity, and religion affect delivery of services; grief and loss; substance abuse and mental health among lesbian Latinas; sex and sexually transmitted diseases; and issues surrounding medical prognosis and religious beliefs in end-of-life care. Available at <http://www.fanlight.com/catalog/subjects/culture.php>.
  - *Worlds Apart* is a video and study guide used as a training tool for raising awareness about the role socio-cultural barriers play in patient-provider communication and health care for culturally and ethnically diverse patients.
  - *The Culture of Emotions* is an award-winning program designed to introduce cultural competence and diversity skills to all mental health clinicians and students. Available on video and also on DVD with a facilitator's guide.
  - *Community Voices* is a video and study guide that helps to integrate cultural awareness and skill-building into training programs for all health professionals.
6. University of Medicine and Dentistry New of Jersey Center for Cultural Competency provides a searchable database of resources for health professions education. Available at <http://njms.umdnj.edu/culweb/medical/medical.cfm>.
7. The National Consortium for Multicultural Education for Health Professionals offers a self-study program, *Physician Update: Cultural Competency*, for doctors on cultural competency. Some of the topics presented are patterns of health disparities and strategies to eliminate them, an appreciation for the traditions and beliefs of diverse patient populations at multiple levels, the impact of stereotyping on medical decision-making; cross-cultural clinical skills, and working effectively with interpreters. Available at <http://culturalmeded.stanford.edu/pdf%20docs/INFORMED%20NJCC-Final.pdf>.
8. Georgetown University National Center for Cultural Competence offers several resources including the following:
  - *Cultural Competence Health Practitioner Assessment* is an online self-assessment and educational tool. Available at <http://www11.georgetown.edu/research/gucchd/nccc/features/CCHPA.html>.
  - Several versions of the *Promoting Cultural and Linguistic Competency: Self-Assessment Checklist* apply to different types of staff and personnel. Available at <http://www11.georgetown.edu/research/gucchd/nccc/information/providers.html>.
9. The collaborative *Initiative for Decreasing Disparities in Depression* is a provider self assessment incorporating cultural and linguistic competence in diagnosis and treatment of depression. Available at <http://www.i-3d.org/>.
10. Manhattan Cross Cultural Group's *Quality Interactions* is an e-learning program that provides cultural competency and cross-cultural communication training for physicians, nurses, and health care staff. Available at <http://www.qualityinteractions.org>.
11. Passport Health Plan created a video for associate and provider training focusing on refugees, their journeys to the United States, and the hardships experienced as they try to assimilate to Western culture. Available at [http://www.youtube.com/watch?v=xZYI0\\_gU-o8](http://www.youtube.com/watch?v=xZYI0_gU-o8).
12. Arab Community Center for Economic and Social Services' *Guide to Arab Culture: Health Care Delivery to the Arab American Community* is a primer to train and educate health providers how to provide culturally meaningful care to Arab Americans. Available at [http://www.accesscommunity.org/site/DocServer/health\\_and\\_research\\_cente\\_21.pdf?docID=381](http://www.accesscommunity.org/site/DocServer/health_and_research_cente_21.pdf?docID=381).
13. The Islamic Medical Association of North America offers *Islam and Medicine* as an online course that focuses on the behavioral and cultural aspects and beliefs of Muslim patients in the clinical ambulatory setting. The course also covers the management of hospitalized and critically ill patients. Available at <http://www.imana.org/education.html>.
14. The Robert Wood Johnson Foundation and Center for Health Care Quality at The George Washington University have developed a short educational video and presentation to explain to providers the importance of identifying and addressing racial and ethnic disparities in

care. The video examines the definition of health care disparities and academic evidence of its existence and presents tested solutions to identify and address disparities. Available at <http://rwjf.org/newsroom/product.jsp?id=44448>.

15. The American Speech-Language-Hearing Association Web site includes several tools for “Self-Assessment for Cultural Competence.” Available at <http://www.asha.org/practice/multicultural/self.htm>.
16. Department of Health and Human Services Health Research and Services Administration offers several resources within its *Cultural Competency Resources including the Quality Health Services for Hispanics: The Cultural Competency Component*. Practical guidance in the form of strategies, tools, and resources for implementing and integrating cultural and linguistic competency content and methods into existing academic programs also provide guidance for evaluating cultural and linguistic competency efforts. Available at <http://www.hrsa.gov/culturalcompetence>.
17. Department of Health and Human Services Office of Minority Health offers several resources including the following:
  - *Think Cultural Health* has online continuing education modules for physicians, physician assistants, and nurses to bridge the health care gap through cultural competency training. Available programs include: *A Physician’s Practical Guide to Culturally Competent Care*; *Culturally Competent Nursing Care: A Cornerstone of Caring*; and *Competency Curriculum for Disaster Preparedness and Crisis Response*. Available at <https://www.thinkculturalhealth.org>.
  - *Two-Year Evaluation Report of the Cultural Competency Curriculum Modules* offers findings of a two-year evaluation of the impact of cultural competency curriculum modules on physicians’ knowledge, attitude, and skills in the provision of culturally competent care. Available at <https://www.thinkculturalhealth.org/cccm/papers/Evaluation%20Report%20final.pdf>.
18. Ring J., et al.: *Curriculum for Culturally Responsive Health Care: The Step-by Step Guide for Cultural Competency Training*. Abingdon, United Kingdom; Radcliffe Publishing, 2008.
19. Mutha S, Allen C, Welch M.: *Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies*. San Francisco, CA: Center for the Health Professions, University of California San Francisco, 2002.

## Competencies for Interpreters and Translators

1. The following organizations have developed a code of ethics, standards of practice, or are working toward national certification for health care interpreters:
  - National Council on Interpreting in Health Care. Available at <http://www.ncihc.org>.
  - California Health Care Interpreters Association. Available at <http://www.chiaonline.org>.
  - International Medical Interpreting Association. Available at <http://www.imiaweb.org>.
  - Certification Commission for Healthcare Interpreters. Available at <http://www.healthcareinterpretercertification.org>.
  - National Board of Certification for Medical Interpreters. Available at <http://www.certifiedmedicalinterpreters.org>.
  - ASTM (formerly the American Society for Testing and Materials). Available at <http://www.astm.org>.
  - Registry of Interpreters for the Deaf. Available at <http://www.rid.org>.
  - American Translators Association. Available at <http://www.atanet.org>.

## Provision of Care, Treatment, and Services Domain Improving Overall Patient–Provider Communication

1. The Patient–Provider Communication Web site provides an interdisciplinary forum that offers an annotated bibliography and a collection of resources to help support two-way communication between patients and providers. Available at <http://www.patientprovidercommunication.org>.

## Developing Language Access Services for Patients Who Speak a Language Other Than English

1. The Department of Health and Human Services Office of Minority Health’s *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations* helps health care organizations implement effective language access services to meet the needs of their LEP patients. This guide is Web-based and provides comprehensive guidance for developing a program to meet diverse patient language needs. Available at <http://raceandhealth.hhs.gov/templates/content.aspx?ID=4375&lvl=3&lvlID=52>.

2. Department of Health and Human Services Office for Civil Rights' "Example of a Policy and Procedure for Providing Meaningful Communication with Persons with Limited English Proficiency" includes guidance and sample language for developing policies and procedures. Available at [http://www.hhs.gov/ocr/civilrights/resources/providers/medicare\\_providers/exampleofapolicyandprocedureforlep.html](http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/exampleofapolicyandprocedureforlep.html).
3. The National Health Law Program offers several resources including the following:
  - *Language Services Resource Guide for Health Care Providers* includes examples of implementation and sample policies for the provision of language services. Available at <http://www.healthlaw.org/images/stories/issues/ResourceGuideFinal.pdf>.
  - *Ensuring Linguistic Access: Legal Rights and Responsibilities* is a comprehensive manual that outlines language access responsibilities under federal and state law, as well as in the private sector, and offers recommendations for addressing identified problems. Available for purchase at [http://www.healthlaw.org/index.php?option=com\\_content&view=article&id=120%3Aensuring-linguistic-access-in-health-care-settings-legal-rights-a-responsibilities&catid=40&Itemid=187](http://www.healthlaw.org/index.php?option=com_content&view=article&id=120%3Aensuring-linguistic-access-in-health-care-settings-legal-rights-a-responsibilities&catid=40&Itemid=187).
  - *What's in a Word: A Guide to Understanding Interpreting and Translation in Health Care* (published in coordination with the National Council on Interpreting in Health Care and American Translators Association) explains the difference between interpreting and translation and the skills needed of interpreters and translators. Available at <http://www.healthlaw.org>.
4. *Talking with Patients: How Hospitals Use Bilingual Clinicians and Staff to Care for Patients with Language Needs* presents findings from a survey to learn more about the individuals in a hospital setting who interact with patients who speak a language other than English. The study focuses on the ways that bilingual clinicians and staff are used, how policies are developed, and how these practices affect the provision of language services. Available at [http://www.calendow.org/Collection\\_Publications.aspx?coll\\_id=22&ItemID=312#](http://www.calendow.org/Collection_Publications.aspx?coll_id=22&ItemID=312#).
5. Industry Collaboration Effort's *Better Communication, Better Care: Provider Tools to Care for Diverse Populations* provides practical tip sheets for providers and clinical staff on how to interact with diverse patients, minimize miscommunication, and build sensitivity to differences. The topics include language proficiency (for example, how

to identify a patient's language, how to locate and work with interpreters, common signs that can be used to communicate across language barriers), cultural background (for example, unique cultural beliefs and practices to be aware of when talking to a patient about sex, pain medication, pregnancy, and breastfeeding), and general tips for working with diverse patients (for example, nonverbal communication, addressing health literacy). Available at [http://www.iceforhealth.org/library/documents/ICE\\_Booklet.pdf](http://www.iceforhealth.org/library/documents/ICE_Booklet.pdf).

### Translating Materials into Other Languages and Sources for Materials in Other Languages

1. The Hablamos Juntos Web site provides solutions for improving communication to LEP patients, including resources for interpreters, toolkits for improving translation services, and information on how to use universal symbols to communicate. Available at [http://www.hablamosjuntos.org/resource\\_guide\\_portal/default.asp](http://www.hablamosjuntos.org/resource_guide_portal/default.asp).
2. The EthnoMed Web site provides cultural profiles including information about languages, family structure, nutrition and food, views of health care and general etiquette. Multi-language patient education materials on a variety of medical conditions are also available. Available at <http://ethnomed.org>.
3. The Health Information Translations Web site provides multi-language patient education materials and hospital signage. Available at <http://www.healthinfotranslations.com/about.php>.
4. The National Network of Libraries of Medicine provides a database of consumer health information in many languages. Available at <http://nnlm.gov/outreach/consumer/multi.html>.
5. Healthy Roads Media is a portal that houses materials in 18 different languages in many formats, including print, audio, multimedia, Web video, and mobile video. Available at <http://www.healthyroadsmedia.org>.
6. The 24 Languages Project, from the Spencer S. Eccles Health Sciences Library and the Utah Department of Health which is now housed on the EthnoMed Web site, has audio recordings and health brochures in English as well as 24 other languages. Available at <http://ethnomed.org/patient-education/immunization/immunization>.
7. Medline Plus has health information in multiple languages in a database of more than 45 different languages,

- including American Sign Language, organized by language and health topic. Available at <http://www.nlm.nih.gov/medlineplus/languages/languages.html>.
8. Tufts University maintains the SPIRAL (Selected Patient Information in Asian Languages) Web site that provides print health information in various Asian languages. Available at <http://www.library.tufts.edu/hhsl/spiral/japanese.shtml>.
  9. The Diversity Health Institute Clearinghouse is Australia's national clearinghouse for multicultural health information and resources for patients and providers. Available at <http://203.32.142.106/clearinghouse>.
  10. Eastern Health, an Australian health system, has cue cards available in over 60 languages for providers and staff in nursing homes and hospitals to help understand patient needs. Available at <http://www.easternhealth.org.au/services/cuecards/default.aspx#cuecards>.
  11. Refugee Health Information Network provides health information about communicable disease, chronic disease, and children, women's health, and primary care available in multiple languages; links to government information on availability of health services, benefits, and programs with a specific focus on refugees and immigrants; and information about different state refugee and immigrant health programs for health providers which provide protocols for screening, testing, and educating refugees and asylees. Available at <http://www.rhin.org>.
  12. National Center for Cultural Competence's *A Guide to Choosing and Adapting Culturally and Linguistically Competent Health Promotion Materials* provides information to help organizations make appropriate choices among existing health promotion materials and includes recommendations to adapt such materials for use in health promotion efforts. Available at [http://www11.georgetown.edu/research/gucchd/nccc/documents/Materials\\_Guide.pdf](http://www11.georgetown.edu/research/gucchd/nccc/documents/Materials_Guide.pdf).
- certain disease or condition. Topics include pregnancy and infant care, asthma, depression, breast cancer, nutrition, and general health beliefs. Profiles include information about the culture's traditional beliefs about a disease or condition, including concepts of disease recognition, causation, and treatment. Available at <http://www.rhin.org>.
3. National Center for Cultural Competence's *Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs* discusses the role of a cultural broker in improving cultural competency in health care settings. Available at [http://www11.georgetown.edu/research/gucchd/NCCC/documents/Cultural\\_Broker\\_Guide\\_English.pdf](http://www11.georgetown.edu/research/gucchd/NCCC/documents/Cultural_Broker_Guide_English.pdf).
  4. HealthCare Chaplaincy's two publications *A Dictionary of Patients' Spiritual & Cultural Values for Health Care Professionals* and *Cultural and Spiritual Sensitivity—A Learning Module for Health Care Professionals* provide cultural, religious, and spiritual guides, self-assessment tools, and tips for cultural, religious, and spiritual sensitivity. Available at <http://www.healthcarechaplaincy.org/chaplaincy-pastoral-care-management/improve-your-patient-care-through-cultural-competency.html>.
  5. *The Rehabilitation Provider's Guide to Cultures of the Foreign-Born*, a 13-volume series from the Center for International Rehabilitation Research Information and Exchange, contains specific information about various cultures that rehabilitation service providers can use to more effectively meet the needs of foreign-born recipients of rehabilitation services. Available at <http://cirrie.buffalo.edu/monographs/index.php>.

## Addressing Religious and Spiritual Beliefs and Practices

1. The Association of Professional Chaplains offers several resources including the following:
  - A reference page for administrators contains numerous resources to help hospital administrators and directors plan and implement effective chaplain departments, including a hospital plan for chaplain services departments, a crosswalk of Joint Commission standards for chaplain departments, sample job descriptions, chaplain assessment and documentation, and articles regarding identifying and incorporating spiritual and religious beliefs and values into patient care. *Standards of Practice for Professional Chaplains* affirm what it means to be a professional chaplain. Available at <http://professionalchaplains.org/index.aspx?id=203>.

## Respecting, Understanding, and Addressing Cultural Beliefs

1. EthnoMed is a Web site that provides cultural profiles including information about languages, family structure, nutrition and food, views of health care and general etiquette. Multi-language patient education materials on a variety of medical conditions are also available. Available at <http://ethnomed.org>.
2. Refugee Health Information Network provides cultural profiles giving a brief overview of a culture's view of a

- *Professional Chaplaincy: Its Role and Importance in Healthcare*, which describes the role and significance of spiritual care. This publication is the first joint statement on the subject prepared by the five largest chaplaincy organizations in North America. Available at <http://professionalchaplains.org/index.aspx?id=229>.
  - *We Speak the Language: Chaplains Offer Vital Role in Patient Centered Communication* describes, with case illustrations, how professional chaplains help identify cultural and religious beliefs and values that are important elements of patient and family understanding and communication with the health care team. Available at <http://professionalchaplains.org/uploadedFiles/pdf/We%20Speak%20the%20Language%20Handzo%20Wintz%20Oct06%20Healing%20Spirit.pdf>.
2. HealthCare Chaplaincy's *A National Survey of Health Care Administrators' Views on the Importance of Various Chaplain Roles* addresses eleven chaplain roles and functions as viewed by hospital administrators to support the emotional and religious needs of patients. Available at <http://www.healthcarechaplaincy.org/userimages/a-national-survey-of-health-care-admin-views-on-chapl-roles.pdf>.
  3. *The Southern Medical Journal* details the doctor's and chaplain's roles in caring for the patient's spirituality in Hanzo and Koenig's 2004 article "Spiritual care: Whose job is it anyway?" It recommends spiritual assessment as part of the patient's overall assessment. Available by request from HealthCare Chaplaincy at <http://www.healthcarechaplaincy.org/chaplaincy-research-resources/articles-by-request.html>.
  4. LaRocca-Pitts, in the September 2006 article "A new hospitalist in the house: The in-house chaplain's role on the hospital medical team" published in *The Hospitalist*, draws a comparison between chaplains and hospitalists. Available at [http://www.the-hospitalist.org/details/article/239573/A\\_New\\_Hospitalist\\_in\\_the\\_House.html](http://www.the-hospitalist.org/details/article/239573/A_New_Hospitalist_in_the_House.html).
  5. American Geriatrics Society's *Doorway Thoughts: Cross-Cultural Health Care for Older Adults, Volume III* is designed to help physicians and other health providers develop a better understanding of the role that religion plays in the health care decision making of patients and their families. This volume contains chapters about Buddhism, Confucianism, Hinduism, Islam, Judaism, Shamanism practiced by Hmong, and Sikhism. Each chapter concludes with a case study that illustrates the application of concepts presented in the chapters. Book description and purchase information available at [http://www.americangeriatrics.org/publications/shop\\_publications/education\\_\\_clinical\\_tools\\_for\\_health\\_care\\_providers/](http://www.americangeriatrics.org/publications/shop_publications/education__clinical_tools_for_health_care_providers/).
  6. The Tanenbaum Center for Interreligious Understanding (<http://www.tanenbaum.org>) published *The Medical Manual for Religio-Cultural Competence: Caring for Religiously Diverse Populations* that includes communication tips and guides, information on ten of the world's largest religions and how they intersect with health care and real tools to help providers manage their patients' religious needs. Available for purchase at <http://www.amazon.com/Medical-Manual-Religio-Cultural-Competence-Religiously/dp/B0033T7O8Q>.
  7. Healthy House's program *Shaman and Physicians Partner for Improving Health for Hmong Refugees* offers an opportunity to the Hmong shaman and physicians from the local hospital to exchange health care experiences and information. More information available at <http://www.healthyhousemerced.org> and <http://www11.georgetown.edu/research/gucchd/nccc/documents/Hmong%20Refugees.pdf>.

### Addressing the Needs of Patients with Disabilities

1. The Barrier Free Healthcare Initiative provides resources on its Web site specifically addressing health care access for people with disabilities, including listing some of the common barriers faced by people with disabilities. Available at <http://thebarrierfreehealthcareinitiative.org>.
2. World Institute on Disability's video *Access to Medical Care: Adults with Physical Disabilities* offers physicians, dentists, nurses, social services, and support staff an introduction to crucial issues that affect the quality of care for patients with disabilities in outpatient clinical settings. A training curriculum is also available. A free preview and purchase information are available at <http://www.wid.org/programs/health-access-and-long-term-services/access-to-medical-care-adults-with-physical-disabilities>.
3. The Center for Universal Design and The North Carolina Office on Disability & Health's *Removing Barriers to Health Care: A Guide for Health Professionals* provides guidelines and recommendations for ensuring equal use of facilities and services by all patients. Available at <http://www.fpg.unc.edu/~ncodh/removingbarriers/removingbarrierspubs.cfm>.
4. The *Checklist for Readily Achievable Barrier Removal* is based on the four priorities recommended by the Title III

regulations in the Americans with Disabilities Act for planning readily achievable barrier removal projects. Available at <http://www.ada.gov/racheck.pdf>.

5. *Access to Medical Care for Individuals with Mobility Disabilities* Guidelines from the Department of Justice Civil Rights Division. Available at [http://www.ada.gov/medicare\\_mobility\\_ta/medicare\\_ta.pdf](http://www.ada.gov/medicare_mobility_ta/medicare_ta.pdf).

## Addressing the Needs of Patients with Physical or Cognitive Communication Needs

1. The Montreal Cognitive Assessment is a cognitive screening test designed to help health professionals detect mild cognitive impairment. It is available in multiple languages. Available at <http://www.mocatest.org>.
2. The Hanen Centre offers *It Takes Two* guides, available in multiple languages, that teach parents of children with language delays how to help their children communicate and learn the language. Available at <http://www.hanen.org/MyHanen/Store/Default.aspx?workshopTypeID=4&categoryID=1>.
3. The Center for Bilingual Speech and Language Disorders, a provider of individual speech and language therapy, offers continuing education programs and several references and resources for health professionals. Available at <http://www.cbsld.com>.
4. North Carolina Office on Disability and Health and Woodward Communications' *Removing Barriers: Tips and Strategies to Promote Accessible Communication* provides information and tips on effectively communicating and interacting with people with disabilities including information about communication aids and tips for creating inclusive print, video and computer-based materials. Available at <http://www.fpg.unc.edu/~ncodh/pdfs/rbtipsandstrategies.pdf>.
5. The American Speech-Language-Hearing Association Web site provides background information, CME courses, a communication bill of rights, and best practice policies on augmentative and alternative communication (AAC) using signs, gestures, pictures, and computers to facilitate communication. Available at <http://www.asha.org>.
6. The International Society for Augmentative & Alternative Communication offers an introductory DVD demonstrating how AAC is used with disabilities along with a handbook (available in English and Spanish) *Communication Without Speech: Augmentative and Alternative Communication Around the World* that discusses

communication interaction, barriers to AAC, and solutions to a variety of communication challenges. Available for purchase at <http://www.isaac-online.org/en/publications/buy/books.php>.

7. Department of Health and Human Services Office for Civil Rights' example policy "Auxiliary Aids and Services for Persons with Disabilities" provides guidance and sample language for developing policies and procedures for effective patient communication. Available at [http://www.hhs.gov/ocr/civilrights/resources/providers/medicare\\_providers/exauxaids.html](http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/exauxaids.html).

## Addressing the Needs of Patients Who Are Blind or Have Low Vision

1. The Council of Citizens with Low Vision International's Web site has information on technology and services for individuals who are blind or have low vision. Available at <http://www.cclvi.org>.
2. MedivoRx offers Rex, a disposable talking prescription bottle, that provides audible label information with a push of a button and makes information about medications more accessible to people who are elderly, visually and cognitively impaired, illiterate, or speak a different language. Available at <http://www.rxtalks.com>.
3. Department of Justice offers a Business Brief on Service Animals. Available at <http://www.ada.gov/svcabrs3.pdf>.

## Addressing the Needs of Patients Who Are Deaf or Hard of Hearing

1. Hard of Hearing Advocates offers a Hard of Hearing Awareness Kit for hospitals and medical facilities that includes a poster, stickers for medical records, a tent card, and an instruction sheet on how to effectively communicate with hearing impaired patients for a nominal price. Available at <http://www.hohadvocates.org/index.php?contenttype=Feature&target=home&subtarget=feature&selected=18>.
2. Communication Access Information Center provides information and resources for Communication Access Real-time Translation or CART, often referred to as real-time captioning, which is the instant translation of the spoken word into English text which appears on a computer monitor or other display. Available at <http://cart-info.org>.
3. The 2004 article by Iezzoni et al., "Communicating about health care: Observations from persons who are deaf or hard of hearing" in *Annals of Internal Medicine*, reports on observations and experiences of patients who are deaf or

hard of hearing and makes suggestions for improving care for these individuals. Available at <http://www.annals.org/cgi/reprint/140/5/356.pdf>.

4. Registry of Interpreters for the Deaf's *Interpreting in Health Care Settings* has information about sign language interpreters, qualifications for interpreters, when an interpreter is needed, and how to access interpreters. Available at [http://www.rid.org/UserFiles/File/pdfs/Standard\\_Practice\\_Papers/Drafts\\_June\\_2006/Health\\_Care\\_Settings\\_SPP.pdf](http://www.rid.org/UserFiles/File/pdfs/Standard_Practice_Papers/Drafts_June_2006/Health_Care_Settings_SPP.pdf).
5. The CATIE Center at the College of St. Catherine's "ASL and English Resources for Interpreting in Medical Settings" Web site has links to information for health care providers working with interpreters and providing care for patients who are deaf, deaf-blind or hard of hearing and includes tips for working with medical interpreters. Available at <http://www.medicalinterpreting.org/Providers/index.html>.
6. The National Association of the Deaf's Web site provides resources for video remote interpreting (VRI), advocacy and position statements regarding VRI, and recommendations for using VRI in medical settings. Available at <http://www.nad.org/issues/technology/vri>.
7. Pollard et al.'s 2009 article "Adapting health education material for deaf audiences," published in *Rehabilitation Psychology*, discusses a method for creating health education material to better suit the needs of deaf patients. Available at <http://psycnet.apa.org/index.cfm?fa=search.displayRecord&cuid=2009-07289-015>.
8. Department of Justice's Business Brief on Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings. Available at <http://www.ada.gov/hospcombr.htm>.
3. *Health Literacy Innovations' Health Literacy & Plain Language Resource Guide* compiles resources to facilitate health literacy. It includes links to action plans, guides, and toolkits, as well as software tools, government resources, initiatives and programs, and training resources. Available at <http://www.healthliteracyinnovations.com/information>.
4. Medical Library Association's *Health Information Literacy Curriculum* is a resource for providers that defines health literacy and the challenges patients face and addresses the impact of low health literacy on quality patient care. Available at <http://mlanet.org/resources/healthlit/index.html>.
5. American Medical Association offers a video focused primarily on health literacy and its impact on health care. Available at <http://www.ama-assn.org/ama/no-index/about-ama/8035.shtml>.
6. The American College of Physicians offers a video focused on health literacy and how it impacts the patient's understanding of medication and treatment instructions. Available at <http://acpfoundation.org/hl/hlresources.htm>.
7. National Quality Forum's report *Improving Patient Safety through Informed Consent for Patients with Limited Health Literacy* presents the results of a study that examined implementation of Safe Practice 10, which focused on informed consent and patient safety. Lessons learned through four case studies are reviewed, as well as the perspectives of organizations that have not adopted the practice. Based on these findings, a separate *User's Guide* also was developed to help providers implement Safe Practice 10. Available at [http://www.qualityforum.org/Publications/2005/09/Improving\\_Patient\\_Safety\\_Through\\_Informed\\_Consent\\_for\\_Patients\\_with\\_Limited\\_Health\\_Literacy.aspx](http://www.qualityforum.org/Publications/2005/09/Improving_Patient_Safety_Through_Informed_Consent_for_Patients_with_Limited_Health_Literacy.aspx).
8. American Medical Association's *Health Literacy and Patient Safety: Help Patients Understand* is a manual for clinicians that provides information on identifying patients who may have limited health literacy, problems associated with limited health literacy, strategies for improving communication, and tips for creating written materials. Available at <http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf>.
9. America's Health Insurance Plans and Emory University's Health Plan Organization Assessment of Health Literacy Activities was designed to allow health plan evaluation of programs to promote understanding among plan members. Resources can be used in a variety of settings included hospitals. Available at <http://www.ahip.org/>.

## Addressing Health Literacy Needs

1. The Institute of Medicine's Roundtable on Health Literacy periodically releases reports that identify practical implementation strategies to improve health literacy. Available at <http://www.iom.edu/Activities/PublicHealth/HealthLiteracy.aspx>.
2. The Pfizer Clear Health Communication Initiative provides resources and guides for addressing health literacy including a prevalence calculator, tips for recognizing health literacy, fact sheets, and tips for improving communication (such as through AskMe3™ or Fry Testing). Available at <http://www.pfizerhealthliteracy.com/physicians-providers/default.html>.

10. Agency for Healthcare Research and Quality's Health Literacy Universal Precautions Toolkit. Available at <http://www.ahrq.gov/qual/literacy> or <http://www.nchealthliteracy.org/toolkit>.
11. The National Action Plan to Improve Health Literacy. Available at <http://www.health.gov/communication/HLActionPlan>.

### Addressing the Needs of Lesbian, Gay, Bisexual, and Transgender Patients

1. Gay and Lesbian Medical Association's *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients* has general guidelines on creating forms, information on staff sensitivity and training, and sample intake forms. Available at [http://www.glma.org/\\_data/n\\_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf](http://www.glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf).
2. The Human Rights Campaign Web site has several resources including the following:
  - Sample nondiscrimination policy statements regarding sexual orientation and gender identity. Available at <http://www.hrc.org/issues/12640.htm>.
  - *Breaking Down Barriers: An Administrator's Guide to State Law & Best Policy Practice for LGBT Healthcare Access* has recommendations on visitation policies, training on importance of advance directives for LGBT families, education for LGBT families about advance directives, and medical decision-making. Available at [http://www.hrc.org/documents/HRC\\_Foundation\\_-\\_Breaking\\_Down\\_Barriers\\_-\\_An\\_Administrators\\_Guide.pdf](http://www.hrc.org/documents/HRC_Foundation_-_Breaking_Down_Barriers_-_An_Administrators_Guide.pdf).
3. The Boston VA Healthcare System's policy "Management of Transgender Veteran Patients" provides sample background, definitions, and specific language regarding the appropriate treatment for transgender individuals. Available at [http://www.tavausa.org/Management%20of%20Transgender%20Veteran%20Patients\\_7.08.pdf](http://www.tavausa.org/Management%20of%20Transgender%20Veteran%20Patients_7.08.pdf).
4. *The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health* from the American College of Physicians is a comprehensive resource intended for health care professionals, public health officials, researchers, and policy makers working towards eliminating disparities in health care. Available at <https://www.acponline.org/atpro/timssnet/catalog/books/fenway.htm>.
5. *Straight for Equality in Healthcare* from Parents, Families, and Friends of Lesbians and Gays provides guidance for health care workers who want to be more comfortable and responsive to the needs of the LGBT population. Available at <http://community.pflag.org/Document.Doc?id=297>.

### Providing Care at the End of Life

1. Promoting Excellence in End-of Life Care is dedicated to improving health care for dying persons and their families through the work of innovative demonstration projects to address existing models of hospice and palliative care. Available at <http://www.promotingexcellence.org>.
2. National Hospice and Palliative Care Organization provides free, easy-to-understand resources on a variety of end-of-life issues. Available at <http://www.nhpco.org/templates/1/homepage.cfm>.
3. National Comprehensive Cancer Network has developed clinical practice guidelines for the multidisciplinary treatment of physical, emotional, and spiritual distress as well as for palliative care, pain, and treatment for cancer by site. Available at [http://www.nccn.org/professionals/physician\\_gls/f\\_guidelines.asp](http://www.nccn.org/professionals/physician_gls/f_guidelines.asp).
4. The George Washington Institute for Spirituality and Health provides a collection of resources for spiritual or religious assessment and end-of-life care. Available at <http://www.gwumc.edu/gwish/soerce>.
5. The Duke Institute on Care at the End of Life provides a listing of resources for helping patients, families, and professional caregivers cope with spiritual and religious issues at the end of life. Available at <http://www.iceol.duke.edu>.
6. *Last Words: Cultural Approaches to Death and Dying*, commissioned by the Funeral Directors Association of New Zealand, describes 32 ethnic, cultural, or religious approaches to death and dying and is intended for those who work with the dying and those wanting to care for and understand people as they approach death or deal with its aftermath. It offers insight into different cultural beliefs and practices including an explanation of particular foods, remedies, and rituals that are important to different groups. An abstract of the book is available at <http://citiesofmigration.ca/last-words-cultural-approaches-to-death-and-dying>.
7. The End of Life/Palliative Education Resource Center Web site includes a fact sheet (#154) regarding the use of interpreters in palliative care. Available at [http://www.eperc.mcw.edu/fastFact/ff\\_154.htm](http://www.eperc.mcw.edu/fastFact/ff_154.htm).
8. The Alzheimer's Association Campaign for Quality Residential Care's *Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes* provides recommendations to improve the quality of care for residents with dementia in assisted living and nursing homes. Available at [http://www.alz.org/national/documents/brochure\\_DCPRphase3.pdf](http://www.alz.org/national/documents/brochure_DCPRphase3.pdf).



- Costello's 2009 article "Last words, last connections: How augmentative communication can support children facing end of life" in the *ASHA Leader*, focuses on how augmentative communication can support children facing end of life. Available at <http://www.asha.org/Publications/leader/2009/091215/LastWordsLastConnections.htm>.

### Cultural Competency Materials for Specific Populations or Conditions

- Department of Health and Human Services' Web site *Health Professionals: Your Role in Women's Health* discusses cultural competency and women's health. Available at <http://www.womenshealth.gov/health-professionals/cultural-competence/index.cfm>.
- The National Minority AIDS Education and Training Center, which gives health care professionals a culturally relevant framework as they provide primary care to various populations with HIV/AIDS, offers several resources including the following:
  - Be Safe: A Cultural Competency Model for African Americans* discusses the components of the BE SAFE mnemonic, a framework that uses culturally pluralistic content and perspectives based on the following six core elements: barriers to care, ethics, sensitivity of the provider, assessment, facts, and encounters. Available at [http://www.aidsctc.org/pdf/p02-et/et-17-00/be\\_safe.pdf](http://www.aidsctc.org/pdf/p02-et/et-17-00/be_safe.pdf).
  - Be Safe: A Cultural Competency Model for Latinos* addresses culturally relevant topics that providers need to be cognizant of when caring for Latino HIV/AIDS patients. Available at [http://www.aidsctc.org/pdf/p02-et/et-17-00/be\\_safe\\_latino.pdf](http://www.aidsctc.org/pdf/p02-et/et-17-00/be_safe_latino.pdf).
- National Native American AIDS Prevention Center's *Clinician's Guide: Working with Native Americans Living with HIV* is a resource for medical providers who are confronted with cultural challenges presented by Native American patients living with or at risk for HIV infection. Available at [http://www.aidsctc.org/pdf/curricula/clin\\_guide\\_native\\_am.pdf](http://www.aidsctc.org/pdf/curricula/clin_guide_native_am.pdf).
- National Initiative for Children's Healthcare Quality's *Improving Cultural Competency in Children's Health Care: Expanding Perspectives* presents a "change package" of the most promising practices for achieving culturally competent care. Available at [http://www.nichq.org/pdf/NICHQ\\_CulturalCompetencyFINAL.pdf](http://www.nichq.org/pdf/NICHQ_CulturalCompetencyFINAL.pdf).
- American Academy of Pediatrics' guideline *Communicating with Children and Families: From Everyday Interactions to*

*Skill in Conveying Distressing Information* includes recommendations on cultural consideration, working with interpreters, and ensuring effective communication in various situations including informed consent. Available at [http://www.guideline.gov/summary/summary.aspx?view\\_id=1&doc\\_id=13404](http://www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=13404).

### Patient, Family, and Community Engagement Domain Encouraging Patient and Family Engagement

- The Joint Commission's "Speak Up" campaign provides downloadable brochures, written at a low health literacy level, to provide to patients and their families. The brochures, available in English and Spanish, are designed to help patients navigate the health care encounter. Brochures Available at <http://www.jointcommission.org/PatientSafety/SpeakUp>.
- The Institute for Family-Centered Care provides leadership to advance the understanding and practice of patient- and family-centered care in hospitals and other health care settings. The institute offers a multitude of publications, self-assessment tools, an annotated bibliography, and other resources to advance the practice of patient- and family-centered care. Available at <http://www.familycenteredcare.org>.
- The Institute for Family-Centered Care's *Partnering with Patients and Families to Design a Patient- and Family-centered Health Care System: Recommendations and Promising Practices* provides guidance for advancing patient- and family-centered care, specifically for creating partnerships with patients and families in quality improvement and health care redesign. Available at <http://www.familycenteredcare.org/pdf/PartneringwithPatientsandFamilies.pdf>.
- Planetree promotes a model of care that supports the patient and family as active participants in care and decision making and emphasizes patient and family education. The Web site provides information that fosters cultural change in health care organizations and the creation of healing health care environments for patients, families, and staff. Available at <http://www.planetree.org>.
- The Kenneth B. Schwartz Center seeks to strengthen the relationship between patients and caregivers through education, training, and support; advocacy and policy development; and research. The Center supports initiatives that promise both immediate and long-term

- improvements to the patient-caregiver relationship. Available at <http://www.theschwartzcenter.org>.
6. The Agency for Healthcare Research and Quality (AHRQ) provides the latest evidence-based information for improving health on their consumers and patients Web site. Available at <http://www.ahrq.gov/consumer>.
  7. AHRQ launched a national advertising campaign “Questions Are the Answer” to encourage patients to become more involved in their health care by asking questions. More information available at <http://www.ahrq.gov/questionsaretheanswer>.
  8. The National Patient Safety Foundation’s online journal *Focus on Patient Safety* includes articles on patient and family involvement in safety efforts. Available at <http://www.npsf.org/paf/npsfp/fo>.
  9. The Consumers Advancing Patient Safety Web site has articles, books, videos, toolkits, and more with the goal to create a collaborative partnership between providers and consumers of care. Available at <http://www.patientsafety.org>.

### Engaging the Community

1. The Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry developed the *Principles of Community Engagement* to provide public health professionals and community leaders with practical guidelines for engaging the public in community decision making and action for health promotion, health protection, and disease prevention. Available at <http://www.cdc.gov/phppo/pce>.
2. The National Center for Cultural Competence’s policy brief *Engaging Communities to Realize the Vision of One Hundred Percent Access and Zero Health Disparities: A Culturally Competent Approach* provides health care organizations with a rationale for engaging communities in a culturally and linguistically competent manner and guidance on prerequisite policies that serve as a foundation for infusing cultural and linguistic competence into community engagement. Available at <http://www11.georgetown.edu/research/gucchd/nccc/documents/ncccpolicy4.pdf>.
3. Meade et al’s 2007 article “Impacting health disparities through community outreach: Utilizing the CLEAN look (culture, literacy, education, assessment, and networking)” from *Cancer Control* illustrates the application of a CLEAN Look checklist approach in outreach strategies for reaching at-risk Haitian American women in the community. Available at <http://www.moffitt.org/CCJRoot/v14n1/pdf/70.pdf>.
4. The Trust for America’s Health and The New York Academy of Medicine’s *Compendium of Proven Community-Based Prevention Programs* reports on evidence-based disease prevention programs and studies evaluating the effectiveness of community-based disease prevention programs designed to reduce tobacco use, increase physical activity, and/or improve eating habits. The report also includes examples of evidence-based community prevention programs that have helped reduce rates of asthma, falls among the elderly, and sexually-transmitted diseases. Available at <http://healthyamericans.org/report/66/prevention>.



# Glossary

**augmentative and alternative communication (AAC) resources** Systems or devices that attempt to temporarily or permanently compensate and facilitate for the impairment and disability of individuals with severe expressive or language comprehension disorders. AAC may be required for individuals demonstrating impairments in gestural, spoken, and/or written modalities [1].

**auxiliary aids and services** Devices or services that enable effective communication for people with disabilities. Examples include qualified interpreters, note takers, transcription services, written materials, assistive listening devices and systems, telephone communication devices for deaf persons, telephone handset amplifiers, video interpretive services, and open and closed captioning [2].

**bilingual staff** Individuals employed by the hospital who have some degree of proficiency in more than one language. Bilingual staff serve in a dual role for the hospital, providing interpreter services in addition to their primary position.

**care continuum** A concept involving an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care [3].

**cultural competence** The ability of health care providers and health care organizations to understand and respond effectively to the cultural and language needs brought by the patient to the health care encounter. Cultural competence requires organizations and their personnel to do the following: (1) value diversity; (2) assess themselves; (3) manage the dynamics of difference; (4) acquire and institutionalize cultural knowledge; and (5) adapt to diversity and the cultural contexts of individuals and communities served [4].

**culture** Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs,

beliefs, values, and institutions of racial, ethnic, religious, or social groups [5].

**disparities** Racial and ethnic differences in health care that are not attributable to other known factors [6].

**effective communication** The successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from patients, and when patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care.

**family** Two or more persons who are related in any way—biologically, legally, or emotionally. Patients and families define their families [7]. *See also* patient- and family-centered care

**gender expression** The external characteristics and behaviors of individuals that are socially defined as either masculine or feminine, such as dress, grooming, mannerisms, speech patterns, and social interactions. Social or cultural norms can vary widely, and some characteristics that may be accepted as masculine, feminine, or neutral in one culture may not be assessed similarly in another [8]. *See also* gender identity and sexual orientation

**gender identity** A person's innate, deeply felt psychological identification as male or female, which may or may not correspond to the person's body or assigned sex at birth

(meaning what sex was originally listed on a person's birth certificate). A person's gender identity is distinct from his or her sexual orientation [8].

**health literacy** The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions [9].

**interpreter** A person who renders a message spoken/signed in one language into one or more languages [10].

**language services** Mechanisms used to facilitate communication with individuals who do not speak English, those who have limited English proficiency, and those who are deaf or hard of hearing. These services can include in-person interpreters, bilingual staff, or remote interpreting systems such as telephone or video interpreting. Language services also refer to processes in place to provide translation of written materials or signage.

**limited English proficiency (LEP)** A legal concept referring to a level of English proficiency that is insufficient to ensure equal access to public services without an interpreter; the inability to speak, read, write, or understand English at a level that permits an individual to interact effectively with health care providers or social service agencies [11].

**patient- and family-centered care** An innovative approach to plan, deliver, and evaluate health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. Patient- and family-centered care applies to patients of all ages, and it may be practiced in any health care setting [7]. *See also* family

**plain language** A strategy for making written and oral information easier to understand; communication that users can understand the first time they read or hear it. A plain language document is one in which people can find what they need, understand what they find, and act appropriately on that understanding [12].

**sexual orientation** The preferred term used when referring to an individual's physical and/or emotional attraction to the same and/or opposite gender. Heterosexual, bisexual, and homosexual are all sexual orientations. A person's sexual orientation is distinct from a person's gender identity and expression [8].

**staff** As appropriate to their roles and responsibilities, all people who provide care, treatment, or services in the organization, including those receiving pay (for example, permanent, temporary, part-time personnel, as well as contract employees), volunteers, and health profession students. The definition of staff does not include licensed independent practitioners who are not paid staff or who are not contract employees [13].

**surrogate decision-maker** Someone appointed to make decisions on behalf of another. A surrogate decision-maker makes decisions when an individual is without decision making capacity, or when an individual has given permission to the surrogate to make decisions. Such an individual is sometimes referred to as a legally responsible representative [13].

**translator** A person who converts written text in one language into another language [10].

## References:

1. Adapted from Ad Hoc Committee on Service Delivery in the Schools: *Definitions of Communication Disorders and Variations*. Rockville, MD: American Speech-Language-Hearing Association, 1993. Available at <http://www.asha.org/docs/html/RP1993-00208.html>. (Accessed March 3, 2010.)
2. Adapted from U.S. Department of Justice Civil Rights Division: Chapter 3: General Effective Communication Requirements under Title II of the ADA in *ADA Best Practices Toolkit for State and Local Governments*. Washington, DC: U.S. Department of Justice Civil Rights Division, 2007. Available at <http://www.ada.gov/pcatoolkit/chap3toolkit.htm>. (Accessed March 3, 2010.)

3. Evashwick C.: Creating the continuum of care. *Health Matrix* (1): 30-39, Spring 1989.
4. *What Is Cultural and Linguistic Competence?* Agency for Healthcare Research and Quality: Rockville MD, February 2003. Available at <http://www.ahrq.gov/about/cods/cultcompdef.htm>. (Accessed March 1, 2010.)
5. Cross T., et al.: *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*, Volume I. Washington, DC: Georgetown University Center for Child and Human Development, 1989.
6. Smedley B.D., Stith A.Y., Nelson A.R.: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academy Press, 2002.
7. Institute for Family Centered Care: FAQ. Available at <http://www.familycenteredcare.org/faq.html>. (Accessed March 3, 2010.)
8. Delpercio A.: *Healthcare Equality Index 2009*. Washington, DC: Human Rights Campaign Foundation and Gay and Lesbian Medical Association, 2009. Available at [http://www.hrc.org/documents/Healthcare\\_Equality\\_Index\\_2009.pdf](http://www.hrc.org/documents/Healthcare_Equality_Index_2009.pdf). (Accessed March 2, 2010.)
9. U.S. Department of Health and Human Services: 11: *Health Communication in Health People 2010: Understanding and Improving Health*, 2nd Ed. Washington, DC: U.S. Government Printing Office, 2010. Available at <http://www.cdc.gov/nchs>. (Accessed March 3, 2010.)
10. Sampson A.: *Language Services Resource Guide for Health Care Providers*. Washington, DC: The National Health Law Program and the National Council on Interpreting in Health Care, Oct. 2006. Available at [http://www.dynamiclanguage.com/downloads/Healthcare\\_LanguageServicesResourceGuide.pdf](http://www.dynamiclanguage.com/downloads/Healthcare_LanguageServicesResourceGuide.pdf). (Accessed April 16, 2010.)
11. Office for Civil Rights: *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons*. Washington, DC: U.S. Department of Health and Human Services, Office for Civil Rights, 2003. Available at <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>. (Accessed March 2, 2010.)
12. Plain Language Action and Information Network (PLAIN): *What Is Plain Language?* Available at <http://www.plainlanguage.gov>. (Accessed March 2, 2010.)
13. The Joint Commission: *2010 Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace, IL: Joint Commission Resources, 2010.



The Joint Commission



**NHeLP**  
NATIONAL HEALTH LAW PROGRAM