The Joint Commission

- Independent, non-governmental, not-for-profit
- Oldest and largest standards-setting and accrediting body in health care
- Accredits/certifies over 20,000 healthcare organizations and programs
Our Mission: 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.

Vision Statement: All people always experience the safest, highest quality, best-value health care across all settings.
Accreditation Standards

Help organizations measure, assess and improve performance

- Focus on patient and organization functions that are essential to providing safe, high quality care

Multiple accreditation programs, settings

Many standards apply across programs
- Unified approach promotes consistency
- Some program-specific standards
Overview of On-site Survey

- Data-driven, patient-centered
- Evaluating actual care processes
- Opportunity for education
- Unannounced (between 18 and 36 months after previous full survey)
  - Observe under normal circumstances
  - Affirm expectation of continuous compliance
Evaluating Compliance

Compliance is based on:
- Verbal and written information provided
- On-site observations and interviews with staff

Tracer Methodology
- Uses real patients as framework for assessing standards compliance
- Follow experience of care through the entire health care process
Communication and Health Care

- Communication is a cornerstone of patient safety
- Health care is communication-dependent and accurate information is needed for several important processes
- Direct communication can be affected by:
  - Language
  - Culture
  - Hearing or Visual Impairment
  - Health Literacy
  - Cognitive Limitation
  - Medical Procedures
  - Disease
AHRQ: Health Disparities Report

2014 National Healthcare Quality and Disparities Report

- Combined with Quality Report
- What is the status of health care disparities in the US?
- How have disparities changed over time?
- Where is the greatest need to reduce disparities?

AHRQ (2014)
Measures of Person-Centered Care

Percentage of children whose parents reported poor communication was HIGHER for:

- Hispanics and Blacks compared to Whites
- Poor, low-income, middle-income families compared to high-income families
In 2011, over 60 million people spoke a language other than English at home (~21% over age 5)
Language Statistics

Approximately 25.3 million people were identified as limited English proficient (LEP) (~9% population)

Limited English Proficient (LEP): is defined as a patient’s self-assessed ability to speak English less than “very well.”
Language Statistics

Figure 2. English-Speaking Ability for the Top Ten Languages: 2011
(Population 5 years and over who spoke a language other than English at home)

German
French
Tagalog
Arabic
French Creole
Spanish
Russian
Korean
Chinese
Vietnamese

Source: U.S. Census Bureau, 2011 American Community Survey.
Video: Language Barriers

International Medical Interpreter Association (1:42)
Available free at:
http://www.youtube.com/watch?feature=player_detailpage&v=twlNuqacDdY
Communication and Patient Safety

- Joint Commission’s Sentinel Event Database
  - Voluntary reports or through complaint process
  - January 1995 – present

- Organization shares root cause analysis, discussion with Joint Commission staff

- Majority of events have multiple root causes

- **Communication:** Oral, written, electronic, among staff, with/among physicians, with administration, with patient or family

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.
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### Root Cause Information for Delay in Treatment Events

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<thead>
<tr>
<th>Root Cause</th>
<th>Count</th>
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<tbody>
<tr>
<td>Communication</td>
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<tr>
<td>Assessment</td>
<td>716</td>
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<tr>
<td>Human Factors</td>
<td>659</td>
</tr>
<tr>
<td>Leadership</td>
<td>625</td>
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<tr>
<td>Information Management</td>
<td>273</td>
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<tr>
<td>Continuum of Care</td>
<td>245</td>
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<tr>
<td>Care Planning</td>
<td>168</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>141</td>
</tr>
<tr>
<td>Medication Use</td>
<td>71</td>
</tr>
<tr>
<td>Patient Rights</td>
<td>27</td>
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*The majority of events have multiple root causes.*
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<td>Continuum of Care</td>
<td>41</td>
</tr>
<tr>
<td>Patient Education</td>
<td>9</td>
</tr>
</tbody>
</table>
Types of Communication

- Focused analysis for the root cause sub-categories of communication

- Detailed root cause analysis for 843 Sentinel Events out of 1400 total events accepted between July 2006 and October 2008

- Communication identified as a root cause for 533 Sentinel Events reported to The Joint Commission
  - Communication: Oral, written, electronic, among staff, with/among physicians, with administration, with patient or family

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.
Root Cause Sub-Categories of Communication

Sub-categories of Communication as a Root Cause of Sentinel Events (2006-2008)

- Electronic Communication
- With Administration
- Written Communication
- With Patient or Family
- Oral Communication
- With Physician
- Among Staff

Note: Percentages based on sentinel events in which communication was found as the primary root cause (533 events)
Laws and Regulations

Title VI of the Civil Right Act of 1964
- prohibits a recipient of funds from DHHS from discriminating against individuals on the basis of national origin (which includes primary language)

Executive Order 13166
- designed to improve access to federally conducted programs and activities, who as a result of national origin, are limited in their English proficiency.

Americans with Disabilities Act
- No individual shall be discriminated against on the basis of disability (deaf, hard of hearing). A public accommodation shall take steps to provide auxiliary aids and services.
CLAS Standards – The Blueprint

- Released in 2000
- Enhancements in 2014, 15 standards
  - Create a safe and welcoming environment
  - Ensure culturally and linguistically appropriate care
  - Meet communication needs – participate in care, make informed decisions
  - Eliminate discrimination and disparities
Joint Commission Support for Effective Communication

- Joint Commission Accreditation Standards
  - Existing standards
  - Patient-centered communication standards

- Monograph: *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*
  - Example practices
  - Resources from the field
What Really Happens in Hospitals?

- 2007 research study (n=60 hospitals)
- On-site visits
  - Review policies
  - Staff interviews
  - Hypothetical patient
- What challenges to hospitals face?

Download the Report of Findings free at: http://www.jointcommission.org/Advancing_Effective_Communication
Hypothetical Patient – Juan Lopez

- 60-year-old Mexican immigrant
- Limited English proficient
- Limited experience with the U.S. health care system
- 12-year-old English-speaking daughter Juanita
- Suffered appendicitis
- Visits Emergency Department for temporary pain relief
- Cultural health belief
Hypothetical Patient – Juan Lopez

- Triage nurse
- Emergency department physician
- Emergency department nurse
- Radiology tech
- Medical surgery unit for recovery
How would you communicate?

“Luckily we have a lady in housekeeping who speaks Spanish. 90% of our foreign speakers speak that language and she is able to help us…”

– Triage nurse

"We use family…particularly with Bosnian or Laotian [patients]…where they will have smaller kids with them like maybe grade schoolers, we have to use them because [for] languages I can’t identify, that is the only thing we have, so we just go with it”

– ED Nurse

“First of all, I would probably use my little board or notepad, and I would write in English to see if he understands the language. If that is not the case, what I usually do is maybe by some form of sign language try to explain to him that he has severe pain in his abdomen and he probably needs an operation. The other thing I could show him is maybe pictures of a surgeon where he probably has to open up the abdomen to perform the procedure.”

– Emergency Department Physician

What is Health Literacy?

The degree to which individuals have the capacity to obtain, communicate, process, and understand basic health information and services needed to make appropriate health decisions.

(Healthy People 2010; Patient Protection and Affordable Care Act)
The skills of health professionals to provide health information appropriate for their audience is equally important as an individual’s skills.

(National Action Plan to Improve Health Literacy)
Impact of Low Health Literacy

- Navigating the health care system
- Filling out forms and questionnaires
- Understanding medicine and human biology
- Advocating for your care
- Communicating with providers
In 2007, over 55 million people spoke a language other than English at home (US Census Bureau, 2010)

Approximately 24.5 million people were identified as limited English proficient (LEP) (US Census Bureau, 2010)
- Limited English Proficient (LEP) is defined as: a patient’s self-assessed ability to speak English less than “very well.”

LEP patients have varying degrees of health literacy
- Despite limited abilities in English, may have high-level abilities in their native language
- Cultural considerations regarding how patient perceives illness and approaches treatment
Joint Commission Support for Effective Communication

- Joint Commission Accreditation Standards
  - Existing standards
  - Patient-centered communication standards

- Monograph: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals
  - Example practices
  - Resources from the field
Existing Accreditation Standards

- Staff orientation on cultural diversity *(HR.01.04.01, EP 5)*
- Comply with law and regulation *(LD.04.01.01)*
- Contracted services provided safely/effectively *(LD.04.03.09)*
- Patient education meets patient needs *(PC.02.03.01)*
- Medical record contains patient language needs *(RC.02.01.01, EP 1)*
- Right to effective communication *(RI.01.01.01, EP 5)*
- Provide interpreting/translation services *(RI.01.01.03, EP 2)*
- Patient participation in care *(RI.01.01.02)*
- Informed consent *(RI.01.03.01)*
2 Main Goals:

- Develop accreditation standards for hospital program
  - Broader issues of communication, cultural competence, patient- and family-centered care
  - Build on previous studies, research projects, and evidence from current literature
  - Multidisciplinary Expert Advisory Panel

- Develop guidance monograph for field
  - *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*
  - Collaboration with National Health Law Program (NHeLP)
Implementation Plan for Standards

- Approved in December 2009
- Released to field in January 2010
- Published in 2011 Hospital manuals

- Surveyors evaluated compliance with standards
- Findings did not affect the accreditation decision

- Inclusion in accreditation decision on July 1, 2012
  - RI.01.01.01, EPs 28 and 29 were implemented July 1, 2011
Patient-Centered Communication Standards

- Qualifications for language interpreters/ translators *(HR.01.02.01, EP 1)*
- Identify communication needs *(PC.02.01.21, EP 1)*
- Address communication needs *(PC.02.01.21, EP 2)*
- Provide language services *(RI.01.01.03, EP 2)*
- Collect preferred language data *(RC.02.01.01, EP 1)*
- Collect race and ethnicity data *(RC.02.01.01, EP 28)*
- Allow patients access to a support individual *(RI.01.01.01, EP 28)*
- Ensure care free from discrimination *(RI.01.01.01, EP 29)*
Qualifications for Interpreters

Standard HR.01.02.01 The hospital defines staff qualifications.

Element of Performance (HR.01.02.01)
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.
Effective Patient-Provider Communication

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

Rationale
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, and that patients with limited English proficiency are more likely to experience adverse events than English speaking patients.
Elements of Performance (PC.02.01.21)

1. The hospital identifies the patient’s oral and written communication needs, including the patient’s preferred language for discussing health care.

**Note:** *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.*

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.
Right to Effective Communication

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

Elements of Performance (RI.01.01.03)

2. The hospital provides language interpreting and translation services.

Note: Language interpreting options may include hospital-employed language interpreters, contract interpreting services, or trained bilingual staff. These 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.

3. The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient’s needs.
Collection of Patient-Level Data

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

**Element of Performance**

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 patient’s communication needs, including preferred language for discussing health care

**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 is documented in the medical record.
Standard RC.02.01.01 The medical record contains information that reflects the patient’s care, treatment, and services.

Element of Performance
28. The medical record contains the patient’s race and ethnicity.
Access to a Support Individual

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

Element of Performance

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: 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.
Non-Discrimination in Care

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

Element of Performance
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.
Roadmap for Hospitals

Inspire hospitals to integrate effective communication, cultural competence, and patient- and family-centered care into system of care

Recommended issues to address to meet unique patient needs, above and beyond standards

Implementation examples, practices, and “how to” information

Download Roadmap for Hospitals free at: http://www.jointcommission.org/Advancing_Effective_Communication
Recommendations from the *Roadmap*

**Effective Communication**

- Develop a system to provide language services *(supporting PC.02.01.21, RI.01.01.01, RI.01.01.03)*
  - Determine the types of services needed
  - Offer a mixture of language services to ensure coverage
  - Train staff on how to access services and work with interpreters
  - Note the use of language services in the medical record
  - Provide translated written documents for frequently encountered languages
## Translated Documents

<table>
<thead>
<tr>
<th>Vital Documents</th>
<th>Non-Vital Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Informed consent documents</td>
<td>• Menus</td>
</tr>
<tr>
<td>• Complaint forms</td>
<td>• Third-party documents, forms, or pamphlets distributed as a public service</td>
</tr>
<tr>
<td>• Information about free language assistance programs or services</td>
<td>• Large documents such as enrollment handbooks (although vital information contained within these documents may need to be translated)</td>
</tr>
<tr>
<td>• Notices or eligibility criteria for, rights in, denial or loss of, or decreases in benefits or services</td>
<td>• General information intended for informational purposes only</td>
</tr>
<tr>
<td>• Intake forms that may have clinical consequences</td>
<td></td>
</tr>
</tbody>
</table>

Recommendations from the *Roadmap*

- Ensure competence of individuals providing language services
  - Define qualifications for language interpreters and translators *(supporting Note to HR.01.02.01)*
  - Review qualifications for contracted language services or external vendors *(supporting LD.04.03.09)*
  - Consult resources for additional guidance (IMIA, NCIHC, ATA)
  - Consider certification for sign language interpreters
  - Consider certification for spoken language interpreters
Recommendations from the *Roadmap*

- Integrate health literacy strategies into patient discussions and materials (*supporting PC.02.01.21, Ri.01.01.03*)
  - Develop written materials that meet patient needs
  - Develop non-written patient education options (audio, video)
  - Pilot test materials with patients, community, local adult literacy programs

- Support patient’s ability to understand and act on health information
  - How do you prefer to receive information (written, verbal)
  - Teach back method
Recommendations from the *Roadmap*

- Tailor the informed consent process *(supporting RI.01.03.01)*
  - Written documents – plain language, format, pictures
  - Readability level, translated materials

- Provide patient education that meets needs *(supporting PC.02.03.01)*

- Engage patients and families in the care process and discharge instruction
  - Encourage patient and family to ask questions
  - Consider follow-up phone call to review instructions
Health Literacy Resources

- National Patient Safety Foundation: Ask Me 3
- HHS: Health Literacy Action Plan
  - 7 goals to improve health literacy with related strategies
- AHRQ/UNC: Universal Precautions Toolkit
  - Systematic approach to reducing the complexity
- Joint Commission: Speak Up
Recommendations from the *Roadmap*

- Incorporate communication, cultural competence, and patient- and family-centered care issues into staff training curricula
  - Encourage staff to improve overall communication skills (patient-provider, provider-provider)
  - Inform staff of federal and state laws and regulations that support these issues *(supporting LD.04.01.01)*

- Identify staff concerns or suggested improvements for providing care that meets patient needs
  - Conduct a staff survey regarding the use of language services and auxiliary aids, barriers to accommodating cultural and religious needs *(supporting PC.02.01.21)*
Mandatory Cultural Competence Training

- **Blue** denotes legislation requiring (WA, CA, CT, NJ, NM) or strongly recommending (MD) cultural competence training that was signed into law.
- **Red** denotes legislation that has been referred to committee and is currently under consideration.
- **Yellow** denotes legislation that died in committee or was vetoed.

thinkculturalhealth.hhs.gov
Recommendations from the *Roadmap*

- Collect feedback from patients, families, and the surrounding community
  - Review complaint resolution system and patient surveys
  - Invite patients and families to participate in focus groups, advisory councils
  - Engage local adult literacy or adult basic education programs to provide feedback on written materials

- Share information with the community about hospital efforts to meet unique patient needs
  - Engage the community through public events and health fairs
Recommendations from the *Roadmap*

Cultural Competence

- Develop a system to collect patient race and ethnicity information (*supporting RC.02.01.01, EP 28*)
  - Modify paper or electronic medical records (may involve adding new fill-in spaces, fields, drop-down menus)
  - Use standardized categories to collect data
  - Train staff to collect race and ethnicity data

- Use available population-level demographic data to help determine the needs of the community
  - Use available demographic data, information on health literacy levels, data on sexual orientation
  - Conduct focus groups or interview community leaders to identify changes in community needs/demographics
Collecting Patient-Level Data

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

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
HRET: Disparities Toolkit

Rationale and resources to help organizations collect accurate demographic data.

How to Ask the Questions

We recommend that health care organizations/health plans provide a rationale for why they are asking patients/enrollees for informed communications background. Suggested wording for the rationale is:

“We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background, treatment that all patients receive and make sure that everyone gets the highest quality of care.”

We have found that people feel comfortable responding to the question about race/ethnicity/sex/primary language/disability status, questions, wish for additional clarity, or perhaps prefer to not answer the question at all.

The following link to a response matrix (PPT) provides real world examples of questions people have asked as well as suggested, not all inclusive. You may encounter different scenarios, and you may not hear any concerns from patients after asking these questions a tool for you and your staff, and it is excellent for facilitating dialogue during training sessions.

- Race/Ethnicity
- Language
- Sex
- Disability
Recommendations from the *Roadmap*

- Identify and accommodate cultural, religious, or spiritual beliefs or practices that influence care *(supporting RI.01.01.01, EPs 6 and 9)*
  - Respect the patient’s preferences for modesty and privacy
  - Consult a professional chaplain, if available, to complete a spiritual assessment

- Identify dietary needs or restrictions that affect care *(supporting PC.02.02.03, EP 9)*

- Target recruitment efforts to increase the pool of diverse and bilingual candidates
Recommendations from the *Roadmap*

**Patient- and Family-Centered Care**

- **Ask the patient to identify a support person** *(supporting RI.01.01.01, EP 28)*
  - Explain the purpose of the patient’s support person, including limitations
  - Make staff aware that the patient has chosen a support person

- **Create an environment inclusive of all patients**
  - Incorporate concepts of universal design
  - Provide a diverse collection of magazines and brochures in the waiting areas
  - Make sure navigational signage can be understood by the patient population
Roadmap for Hospitals - Appendices

- A: Checklist of all issues to address
- B: Existing Joint Commission requirements supporting effective communication, cultural competence, and patient- and family-centered care
- C: Joint Commission standards for patient-centered communication
  - Explanation of revision/addition
  - Self-assessment guidelines, practice examples
- D: Laws and regulations
- E: Resource guide
How are Hospitals Doing?

- All patient-centered communication requirements
  - 4 years of data
- Sentinel Event Database
- Compliance data from on-site surveys
- Questions submitted to Standards Interpretation
Sentinel Event Database

Data pulled from 2010 - 2014

Searched for events with root causes related to “language/literacy requirements not addressed”
  - Difficulties and limitations

Themes:
  - Language services available, but not provided
    - Staff were aware of services and how to access
    - Use of family members to interpret
  - No documentation of preferred language, need for interpreter
  - Cultural issues affecting care/treatment decisions

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.
Data from the On-Site Survey

- Evaluating care processes
- Opportunity for education
- Tracer Methodology
  - Uses actual patients as framework for assessing standards compliance
  - Follow experience of care through the entire health care process
Preliminary Data

Data from on-site surveys

Limitations:
- Evaluated, but not incorporated into accreditation decision
- Consultative advice versus Requirement for Improvement (RFI)
- Qualitative data not always included in reports
Noncompliance with Patient-Centered Communication Standards

* not all issues related to communication
Requirement for Improvement (RFI)

- Recommendation that is required to be addressed in order for the organization to retain its accreditation
- Surveyor comments from accreditation survey reports, specifies issues identified on-site
- Data pulled from 2010 - 2014
- All patient-centered communication standards
  - Related issues (patient education, comprehension)
Standards Interpretation Questions

Online question form to submit inquiries

Implementation issues on-site overlap with inquiries from online question form
- Similar themes about data collection, qualifications
- Hospitals with policies, without policies
Collection of Preferred Language Data

- No process to collect data
- Process in place, but not followed
- Incorrect language selected in EHR
- How to collect data
  - Tools, resources available
- When to collect data
  - Assessment, registration
- How frequently to collect data
- Collection of “primary” versus “preferred” language
# FAQ for Preferred Language

**Frequently Asked Questions:**

http://www.jointcommission.org/standards_information/jcfaq.aspx

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### Standards FAQs

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

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<td>October 24, 2013</td>
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#### Record of Care, Treatment, and Services

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#### Rights and Responsibilities of the Individual

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<td>December 10, 2012</td>
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<td>Patient Race and Ethnicity Data Collection</td>
<td>New</td>
<td>August 19, 2011</td>
</tr>
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</table>
Collection of Preferred Language Data

Are organizations required to use the term “preferred” language? My organization is collecting the patient’s “primary” language – does this meet the requirement?

- Goal is to identify language needs of the patient
  - Is an interpreter required at the patient-level?
  - Do services need to be modified at the organization-level?

- Use of alternate or abbreviated terms
  - “preferred” and “primary” differ, but intent is similar
  - “pref lang” to accommodate character limitations in EHR

- Do policies and staff describe the information being collected as the patient’s language for discussing health care?
Qualifications for Interpreters

- No process, qualifications in place
- Use of family members or friends
  - Hospital policy not followed
- Requirements for certification
- Use of translation apps
- Provide qualifications in 30 min

**Use of bilingual staff**
- Clinical versus non-clinical staff
- Use in emergency situations
- Interpreting or directly providing care
Provider Communication Skills

- 2013 white paper
- Consensus recommendations to advance quality of care and **promote** communication between bilingual physicians and LEP patients

“Bilingual” skills
- limited competency
- native speakers
- medical training in a non-English language
Provision of Language Services

- No process in place
  - Process not followed
- No interpreter offered
- Patient refusal of interpreter
- Modes of interpreting
  - In-person, phone, video
- Documenting use of interpreter
- Translated documents
  - Documents available, not provided
  - Wrong documents provided (consent, education)
  - No documents available, use of interpreter
  - Population threshold
Collection of Race and Ethnicity Data

- No process in place
  - No data fields
- No data collected
  - Race only, not ethnicity
- How to collect data
  - Tools, resources
- Recommended categories to use
- Format for data collection
  - Race and ethnicity
  - Race/ethnicity
FAQs for Race and Ethnicity Data

Frequently Asked Questions:
http://www.jointcommission.org/standards_information/jcfaq.aspx

<table>
<thead>
<tr>
<th>Topic</th>
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<td>Provision of Care, Treatment, and Services</td>
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<td>Collecting the Patient’s Preferred Language</td>
<td>New</td>
<td>October 24, 2013</td>
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<tr>
<td>Format for collecting patient race and ethnicity data</td>
<td>New</td>
<td>December 10, 2012</td>
</tr>
<tr>
<td>Patient Race and Ethnicity Data Collection</td>
<td>New</td>
<td>August 19, 2011</td>
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</table>
Collection of Race and Ethnicity Data

Are there specific categories for race and ethnicity that hospitals should use?

- Intent is to identify health disparities
  - Is there a need for new services, programs, initiatives?

- Requirement does not specify categories
  - Flexibility to determine what is appropriate

- Recommended categories:
  - Office of Management and Budget
  - Institute of Medicine report
  - Health Research and Educational Trust toolkit
Can the patient’s race and ethnicity data be collected in the same question?

- 1- or 2-question format
  - Race/ethnicity in same question
  - Race and ethnicity in separate questions

- Preferred method is 2-question format
  - Hispanic ethnicity first
  - Race categories

- Consider granular ethnicity categories
Collecting Patient-Level Data

**Figure 1: Recommended Variables for Standardized Collection of Race, Ethnicity, and Language Need**

<table>
<thead>
<tr>
<th>Race and Ethnicity</th>
<th>OMB Hispanic Ethnicity</th>
<th>OMB Race (Select one or more)</th>
<th>Granular Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hispanic or Latino</td>
<td>Black or African American</td>
<td>Locally relevant choices from a national standard list of approximately 540 categories with CDC/HL7 codes</td>
</tr>
<tr>
<td></td>
<td>Not Hispanic or Latino</td>
<td>White</td>
<td>“Other, please specify: ___” response option</td>
</tr>
</tbody>
</table>

**Spoken English Language Proficiency**

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

*(Limited English proficiency is defined as “less than very well”)*

**Spoken Language Preferred for Health Care**

- Locally relevant choices from a national standard list of approximately 600 categories with coding to be determined
- “Other, please specify: ___” response option
- Inclusion of sign language in spoken language need list and Braille when written language is elicited

Institute of Medicine (2009)
Communication Standards Across Programs

Several patient-centered communication standards are incorporated into other accreditation/certification programs

<table>
<thead>
<tr>
<th>Standard</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifications for language interpreters and translators</td>
<td>Hospital</td>
</tr>
<tr>
<td><em>(HR.01.02.01, EP 1 with Note)</em></td>
<td></td>
</tr>
<tr>
<td>Identify and address communication needs</td>
<td>Hospital, Ambulatory (PCMH), Critical Access Hospital (PCMH), Behavioral Health Home</td>
</tr>
<tr>
<td><em>(PC.02.01.21, EPs 1 and 2)</em></td>
<td></td>
</tr>
<tr>
<td>Provide language services</td>
<td>Hospital, Ambulatory (PCMH), Critical Access Hospital (PCMH)</td>
</tr>
<tr>
<td><em>(RI.01.01.03, EP 2 with Note)</em></td>
<td></td>
</tr>
<tr>
<td>Collect preferred language data</td>
<td>Hospital, Ambulatory</td>
</tr>
<tr>
<td><em>(RC.02.01.01, EP 1 with Note)</em></td>
<td></td>
</tr>
<tr>
<td>Collect race and ethnicity data</td>
<td>Hospital, Ambulatory (PCMH), Behavioral Health Home</td>
</tr>
<tr>
<td><em>(RC.02.01.01, EP 28)</em></td>
<td></td>
</tr>
<tr>
<td>Allow patients access to a support individual</td>
<td>Hospital, Critical Access Hospital</td>
</tr>
<tr>
<td><em>(RI.01.01.01, EP 28)</em></td>
<td></td>
</tr>
<tr>
<td>Ensure care free from discrimination</td>
<td>Hospital, Critical Access Hospital</td>
</tr>
<tr>
<td><em>(RI.01.01.01, EP 29)</em></td>
<td></td>
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</table>
R³ Report  Requirement, Rationale, Reference
A complimentary publication of The Joint Commission  Issue 1, February 9, 2011
Download the R³ Report for free: http://www.jointcommission.org

First issue of R³ Report focuses on the patient-centered communication standards for hospitals

10 minute video on Joint Commission standards and other resources

Highlights 2 educational monographs

Download the video for free:
http://www.jointcommission.org/Advancing_Effective_Communication
# Crosswalk of TJC and CLAS Standards

- Collaborated with Office of Minority Health
- Focused on hospital accreditation standards
- Posted on Joint Commission project website (Summer 2014)

<table>
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<tr>
<th>Requirement</th>
<th>Regulations</th>
</tr>
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<tr>
<td>CLAS 01</td>
<td>Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.</td>
</tr>
</tbody>
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<tr>
<th>Joint Commission Equivalent Number</th>
<th>Joint Commission Standards and Elements of Performance</th>
</tr>
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<tr>
<td>LD.04.01.01</td>
<td>The hospital complies with law and regulation.</td>
</tr>
<tr>
<td>EP 2</td>
<td>The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations.</td>
</tr>
<tr>
<td>LD.04.03.01</td>
<td>The hospital provides services that meet patient needs.</td>
</tr>
<tr>
<td>EP 1</td>
<td>The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements.</td>
</tr>
<tr>
<td>LD.04.03.07</td>
<td>Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.</td>
</tr>
<tr>
<td>EP 2</td>
<td>Care, treatment, and services are consistent with the hospital’s mission, vision, and goals.</td>
</tr>
<tr>
<td>PC.02.01.21</td>
<td>The hospital effectively communicates with patients when providing care, treatment, and services.</td>
</tr>
<tr>
<td>EP 1</td>
<td>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: 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.</td>
</tr>
<tr>
<td>EP 2</td>
<td>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)</td>
</tr>
<tr>
<td>RI.01.01.01</td>
<td>The hospital respects, protects, and promotes patient rights.</td>
</tr>
<tr>
<td>EP 5</td>
<td>The hospital respects the patient’s right to and need for effective communication. (See also RI.01.01.03, EP 1)</td>
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<tr>
<td>EP 6</td>
<td>The hospital respects the patient’s cultural and personal values, beliefs, and preferences.</td>
</tr>
<tr>
<td>EP 9</td>
<td>The hospital accommodates the patient’s right to religious and other spiritual services.</td>
</tr>
<tr>
<td>EP 29</td>
<td>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.</td>
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</table>
Joint Commission Efforts – Past and Present

- Research Study: *Hospitals, Language, and Culture: A Snapshot of the Nation*
- Public Policy White Paper: “*What Did the Doctor Say?:” Improving Health Literacy to Protect Patient Safety*
- Health Equity and Meeting the Needs of the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community
- Speak Up Initiative
Exploring Cultural and Linguistic Services in the Nation’s Hospitals: A Report of Findings

- Released in March 2007
- Download a free copy of the report on HLC website
- Provides an overview of the HLC study
  - Detailed methodology
  - Site visit protocol
  - Recommendations for hospitals, policymakers, and researchers

Download the Report of Findings free at: http://www.jointcommission.org/Advancing_Effective_Communication
One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations

- Released April 2008
- Download a free copy of the report on HLC website
- Thematic framework derived from current practices in 60 hospitals
- Self-assessment tool to tailor initiatives to meet the needs of diverse patient populations

Download One Size Does Not Fit All free at: http://www.jointcommission.org/Advancing_Effective_Communication
Public Policy White Paper: Health Literacy Recommendations

- **Recommendation 1:** Make effective communications an organizational priority to protect the safety of patients

- **Recommendation 2:** Incorporate strategies to address patients’ communication needs across the continuum of care

- **Recommendation 3:** Pursue policy changes that promote improved practitioner-patient communications

Download this report for free at: http://www.jointcommission.org/Advancing_Effective_Communication
Meeting the Needs of LGBT Patients

LGBT Stakeholder Meeting:
To promote effective communication, cultural competence, and patient-and family-centered care for lesbian, gay, bisexual, and transgender (LGBT) patients and families by bringing together stakeholders to identify practices and articulate implementation processes.

Field guide/toolkit addressing LGBT health care in hospitals

Increased awareness among health care providers, consumers, and policymakers

Download the Field Guide for free at: http://www.jointcommission.org/Advancing_Effective_Communication
Speak Up Initiative

Joint Commission’s award-winning patient safety program
- *Know Your Rights*
- *Understanding Your Doctors and Other Caregivers*

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Print/Videos available in English and Spanish

Download for free at: http://www.jointcommission.org/speakup.aspx
For More Information

Please visit our project website: www.jointcommission.org/Advancing_Effective_Communication

Available:
Information on standards and Roadmap for Hospitals
Information on The Field Guide Hospitals, Language, and Culture study information
Links to other websites and resources

Standards inquiries:
Standards Interpretation Group at 630-792-5900
www.jointcommission.org/standards (online form)

My contact information:
ccordero@jointcommission.org or 630-792-5845
Questions?
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