R^3 Report Requirement, Rationale, Reference

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Published for Joint Commission accredited organizations and interested health care professionals, *R^3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also provide a rationale, the rationale provided in *R^3 Report* goes into more depth. The references provide the evidence that supports the requirement. *R^3 Report* may be reproduced only in its entirety and credited to The Joint Commission. To receive by e-mail, visit www.jointcommission.org.

Patient-centered communication standards for hospitals

Requirements

The full text of the patient-centered communication standards is provided in the Joint Commission monograph, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals.* The *Roadmap for Hospitals* provides recommendations to help hospitals address unique patient needs and meet and exceed compliance with the new patient-centered communication standards and other related Joint Commission requirements. The *Roadmap for Hospitals* is available to download for free from http://www.jointcommission.org/Advancing_Effective_Communication/. Selected patient-centered communication standards and elements of performance (EPs) are provided below.

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

EP 1 The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. (Also see 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.*

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. (Also see RI.01.01.03 EPs 1-3)

Tell us what you think about *R^3 Report*

The Joint Commission is interested in your thoughts about the new *R^3 Report* quarterly e-newsletter. Please take a few minutes to complete a short on-line survey. The survey will be open through March 30, 2011. The goal of this survey is to evaluate the effectiveness of this new publication in providing the rationale for The Joint Commission requirement addressed in this issue.

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

EP 28 The medical record contains the patient’s race and ethnicity.

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: *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.)*

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.

Joint Commission surveyors began evaluating compliance with the patient-centered communication standards on January 1, 2011; however, findings will not affect the accreditation decision until January 1, 2012 at the earliest.* The information collected by Joint Commission surveyors and staff during this implementation pilot phase will be used to address common implementation questions and concerns.

Rationale

***** Due to recent changes to the Centers for Medicare & Medicaid Services Conditions of Participation regarding equal visitation rights for all patients, standard RI.01.01.01 EPs 28 and 29 are scheduled for an earlier implementation date, July 1, 2011.

In January 2010, The Joint Commission released a set of new and revised standards for patient-centered communication as part of an initiative to advance effective communication, cultural competence, and patient- and family-centered care. These standards are 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. A growing body of research documents that a variety of patient populations experience less safe or lower quality of care or poorer health outcomes associated with their race, ethnicity, language, disability, or sexual orientation. Among other factors, these studies document that these disparities in health care can be caused by cultural or language barriers that impair communication with caregivers, impeded access to care, or fear of discrimination.[1,2,3,4] Hospitals that do not adequately address cultural, communication, mobility, and other patient needs will continue to put themselves and their patients at risk for negative consequences. The Joint Commission has made several efforts 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. 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]

Reference

Effective Communication (PC.02.01.21 EPs 1 and 2)

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 in a primary language other than English, experience difficulty understanding health information, or may be unable to speak fully or well 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. Research shows that patients with communication problems are at an increased risk of experiencing preventable adverse events,[6] and that patients with limited English proficiency are more likely to experience adverse events than English speaking patients.[5,9] In addition, Title VI of the Civil Rights Act of 1964 prohibits discrimination based on "national origin," which includes language. Federal policies state that "reasonable steps" need to be taken to ensure that limited English proficient patients have "meaningful access" to any program or activity provided by hospitals that receive federal funding.[10,11] The Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination based on disability and require hospitals to provide auxiliary aids and services to effectively communicate with patients who are deaf or hard of hearing.[12,13]

Collecting Race and Ethnicity Data (RC.02.01.01 EP 28)

The collection of patient-level demographic data on race and ethnicity provides 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.[14] Although the Joint Commission standards do not specify how to categorize data when collecting race and ethnicity data, many state reporting entities and payors do specify these requirements. Numerous research studies and reports have shown that racial and ethnic minorities are in poorer health, experience more significant problems accessing care, are more likely to be uninsured, and often receive lower quality health care than other Americans.[1,2,15] Collecting race and ethnicity information for each patient also provides the hospital an opportunity to: better plan for needed services; identify members of a target population to whom elements of an intervention would apply; understand potential patterns in access and outcomes for different segments of the patient population; and increase patient and provider understanding.[16,17]

Access to a Support Individual (RI.01.01.01 EP 28)

Access to a family member, friend, or other trusted individual provides a patient with emotional support, comfort, and alleviates fear during the course of the hospital stay. Some hospitals have implemented unrestricted or flexible visitation hours as part of patient- and family-centered care initiatives. Results indicate that increased visitation hours provide a better understanding of the patient and the patient's problems, better communication, and increased patient satisfaction.[18,19] An increased family presence may also provide some sensory organization to an environment that may be overwhelming to patients. Unrestricted visiting hours can enhance the family's role as a patient support system and allow them to assist with care planning, clarify information and reinforce patient education.[20,21] While the concept of access to a support individual highlighted in RI.01.01.01, EP 28 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 who the patient identifies as important. The Joint Commission has expanded its definition of *family* to include individuals who may not be legally related to the patient, which could incorporate someone who serves as the patient's support person.

Non-Discrimination in Care (RI.01.01.01 EP 29)

Research has shown that perceived discrimination was negatively correlated with health status for African Americans and whites, and individuals who reported discrimination were less likely to receive preventive services.[22,23] In addition, studies of lesbian and bisexual women indicated that disclosing sexual orientation to their physicians would negatively affect their health care,[24] and women who received care from providers who were knowledgeable and sensitive to lesbian issues were significantly more likely to have received a Pap test.[25] There are several federal laws and regulations that protect patients from various forms of discrimination. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on "national origin,"[10] and the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination based on physical disability.[12] However, although these laws and regulations include some anti-discrimination protections, state laws vary and not all potential forms of discrimination are covered. The requirement in RI.01.01.01, EP 29 underscores the importance of providing equitable care to all patients and applies to hospitals nationwide.

Expert panel input

A multidisciplinary Expert Advisory Panel, representing a broad range of stakeholders, provided guidance regarding the principles, measures, structures and processes that serve as the foundation for the patient-centered communication standards. The panel included consumers, clinicians, researchers, purchasers, administrators, educators, quality improvement organization representatives, and others.

Level of evidence

Although The Joint Commission has gathered information from peer-reviewed literature and law and regulation for this requirement, there is no grading of the level of evidence to report.

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