

# SIX MONTHS and COUNTING

**Is Your Hospital Ready for The Joint Commission's  
New Standards for Culturally-Competent Care?**



BY MARK CRAWFORD

**T**he Joint Commission health care standards-setting and accrediting body has targeted Jan. 1, 2011, as the start-up date for its new and revised elements of performance. These are expected to improve the delivery of culturally-competent care by addressing key patient-provider communication issues.

The initiative builds upon The Joint Commission's study entitled "Hospitals, Language and Culture: A Snapshot of the Nation," which evaluated how hospitals in the U.S. respond to the cultural and language needs of minority patients. The elements of performance spring from several of the study's key findings, which showed cultural competency varied greatly among hospitals, and that "hospitals and health systems must communicate more effectively to meet the diverse cultural needs of their patients," said Amy Wilson-Stronks, project director for The Joint Commission's division of quality measurement and research. She is principal investigator for the *Hospitals, Language and Culture* study and co-director of the project to develop the new and revised standards.

Based on this broad research, The Joint Commission convened a panel of experts to discuss the results and develop the new standards. "Over 700 individuals applied to be panel members, a response that demonstrates the high level of interest in this subject across the industry," Wilson-Stronks said.

After pilot tests in selected hospitals, The Joint Commission approved a set of new and revised standards and elements of performance in December 2009. The organization expects to publish them in January 2011, though a formal implementation date has not been announced. The new standards will not count against accreditation, Wilson-Stronks said.

#### FOCUSING ON LANGUAGE

Poor communication brought on by language and cultural differences can be dangerous or even fatal for patients. The Joint Commission's new standards are intended to increase patient safety and quality of care through improved cultural competence, especially regarding language. In many cases, the revisions reflect clarification of existing requirements such as the requirement to provide interpreting and translation services. However, the new standards and elements of performance are designed to further support patient autonomy, safety and effective patient-provider communication by:

- Collecting patient race, ethnicity and language data
- Qualifying language interpreters and translators
- Providing language services
- Identifying and addressing patient communication needs
- Providing nondiscriminatory patient care

"Hospitals definitely struggle with providing access to language interpreters," said Wilson-Stronks. "Most

provide some language service but don't utilize it in an efficient manner. Resources may be limited. To perform well, hospitals need to have a system in place, well-trained staff and the commitment to use the services effectively. Hospitals that invest in language access and cultural competency will likely see improved patient outcomes, higher throughput and fewer patient complaints."

"These are major changes," added Joseph Swedish, president and chief executive of Trinity Health, Novi, Mich., the fourth-largest Catholic health organization in the country. "The standards go a long way toward making cultural competency a fundamental part of the health care industry. We need to be attentive to how different cultures have different needs, and we must have the ability to understand and be clearly understood in their own languages."

Romana Hasnain-Wynia, director of the Center for Healthcare Equity at Northwestern University's Feinberg School of Medicine, agreed. "Hospitals and health systems do a great job of collecting basic data on patients but need to do more on gathering and analyzing demographic characteristics, especially language," she said. "This push by The Joint Commission underscores the importance of lingual and culturally-appropriate care and understanding the patient population on a deeper level."

#### WHERE TO START?

The development of diversity management and cultural competence is uneven across the industry, according to Fred Hobby, president of the American Hospital Association's Institute for Di-

versity in Health Management. "Some hospitals, for example, have full-time interpreters who are supplemented by telephonic services," said Hobby. "Others still rely on bilingual staff or family members in attendance for translation."

Financial resources for cultural competency may also be limited. Language interpreters are expensive, and because their services are currently non-reimbursable, "those costs come right off the bottom line," he said.

Without appropriate language and cultural data or knowing how the community demographic is changing, it is very difficult (and risky) to allocate precious resources toward improving cultural competency. "However," said Hasnain-Wynia, "there is no comparison between the cost of a bad patient outcome and the cost of becoming culturally compliant."

Hobby said, "One thing we have learned from our surveys is that diversity management is still not viewed as a high priority by many organizations, even with the new standards coming online next year. For some hospitals, it will be a short step; for others it will be a major leap."

Diversity leaders in health systems already are paying close attention to

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the changes and adding them to their plans. "Because we've been working on diversity for several years, have a strategy in place and have done a lot of training, we are in pretty good shape for meeting the timeline," said Swedish. For hospitals that lack diversity executives, Hobby recommends forming a cross-sectional diversity council from all departments and across all levels of





leadership to enact plans for gaining more information about patient populations.

“Meeting these [elements of performance] requires a commitment of time and resources, starting with the CEO,” Swedish pointed out. “It can’t just be delegated to someone else who already has too much to do.”

Swedish suggested the following to get on the road to compliance:

- Educate the board. Very few boards mirror the diversity of the community. Encourage the board and executive leadership to examine the mission, vision and value of the hospital. Do they embrace cultural competency? Are the words specific enough?

- Host a diversity summit and include all executive leaders. Bring in the best and brightest talent to present and train.

- Appoint diversity leadership.

- Collect and analyze the appropriate data and study it to better understand the community you serve.

- Educate nursing staff. Nurses touch patients more often than any other health care professional.

#### ADDITIONAL TOOLS

“We have spent the last 10 years talking about hospitals collecting race, ethnicity and primary language data,” said Hasnain-Wynia. “Initially there were lots of reasons raised why it couldn’t be done, but those have all been addressed. Now is the time to make the change. And with the flood of information, tools and online resources now available, the transition shouldn’t be too difficult.”

The American Leadership Council on Diversity in Health Care and other health care organizations will provide tool kits, white papers and other resources for helping hospitals comply with The Joint Commission standards

in a timely manner. For example, the Health Research and Educational Trust Toolkit ([www.hret-disparities.org](http://www.hret-disparities.org)) is a web-based resource that provides hospitals, health systems and health plans with the materials they need to collect and manage race, ethnicity and primary language data. The Joint Commission also prepared an implementation guide to go with it.

The Institute for Diversity in Health Care Management has teamed up with

Simmons College in Boston to provide a certificate of diversity management in health care ([www.simmons.edu/shs/execed/diversity-management/index.shtml](http://www.simmons.edu/shs/execed/diversity-management/index.shtml)). Content for this intensive program includes an executives-in-residence course that facilitates one-on-one interaction with some of the top diversity practitioners in the nation. Cost

for the 12-module, 10-month, 460-hour certificate program is about \$8,000. [See related story on page 24.]

#### INTO THE FUTURE

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“Patients will be more satisfied and vote with their feet,” said Hobby. “They will tell their friends that your hospital respected their beliefs and practices. Second- and third-generation family members will bypass closer facilities because they know they can trust you.

“Sure, the first wave might not be insured and might leave a few bills unpaid; but the second wave will be better educated and have higher income, and the third generation will own well-established businesses and be leaders in the community — and you will be

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THOMAS J. HANSEN, MD

deeply connected with them.”

Medical students also need to be better prepared to carry out these new standards as physicians. Medical schools already teach how diverse cultures and belief systems perceive health and illness and how to recognize and address gender and cultural biases in themselves and others in the process of health care delivery.

“Catholic schools educate medical students in the Catholic tradition,” said Thomas J. Hansen, MD, associate dean for medical education at Creighton University School of Medicine in Omaha. “We focus on caring for the poor, marginalized and widowed and seeing God in every person we meet, which encompasses the full spectrum of diversity.”

There are several ways medical students can better understand cultural competency. The first (and least effective, noted Hansen,) is a classroom lecture. The second is having members of a given cultural group address the class about their experiences in life and in medicine. The third (and Hansen’s favorite) is having students enter these worlds of diverse culture to experience them more fully.

“This is precisely what Jesus did during his active years of ministry,” said Hansen. “Ideally, I think all students should experience the third way — doing things like helping the homeless, living with the poor in the Dominican Republic, spending weeks immersed in a culture — as part of our curriculum to make diversity more tangible and health care more successful.”

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

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