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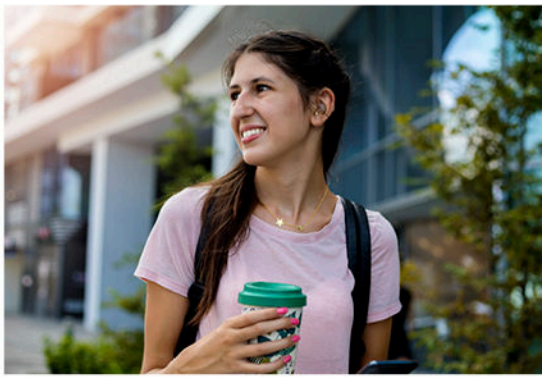

A Toolkit to Support Illinois Hospitals and Healthcare Systems in Caring for Deaf, DeafBlind, and Hard of Hearing Patients

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Foreword

Healthcare organizations strive to deliver exceptional experiences to every patient, including individuals who are Deaf, DeafBlind and/or hard of hearing (DDBHH). However, more resources are needed to address knowledge gaps and organizational readiness amongst healthcare organizations to best support this diverse population. To further this effort, the Illinois Health and Hospital Association (IHA) partnered with 2axend, a Chicagoland based, deaf-owned strategic consulting and training firm that specializes in working with organizations to improve user experiences for their deaf and hard of hearing clients, and member hospitals to develop this toolkit for hospitals and healthcare organizations to enhance signing and non-signing DDBHH individuals' patient experiences and continuum of care.

This comprehensive toolkit is informed by current federal and state law, Joint Commission accreditation standards (including the 2026 National Performance Goals), and best practices established in partnership with the DDBHH community.

Lastly, this toolkit is designed to empower Illinois hospitals and health systems to deliver exceptional, compassionate, and legally compliant care to DDBHH patients. It combines foundational knowledge, practical strategies, and implementation standards to bridge knowledge gaps and enhance organizational readiness.

Introduction to the DDBHH Community

This section serves as a foundational overview, offering insights into the cultural and linguistic diversity of this community and the unique healthcare disparities they face.

Population

With 48 million Americans, including 2 million Illinoisans, identifying as Deaf or hard of hearing, the need for effective communication and accessible healthcare services is more critical than ever. This patient population is not static; it is a growing demographic with immense potential, particularly as advances in healthcare increase life expectancy.

As the U.S. population ages, the prevalence of age-related hearing loss is projected to rise, further expanding the number of people who require support. This demographic shift presents a unique opportunity and a pressing need for healthcare organizations to optimize their services to meet the evolving demands of DDBHH patients across all sectors. The growth of this community underscores the importance of a skilled and dedicated workforce to ensure equal access and quality care for all.

Cultural and Linguistic Diversity

The greater Deaf and hard of hearing community is diverse, with people identifying as Deaf, DeafBlind, DeafPlus, hard of hearing, and late-deafened. It's crucial for healthcare providers to understand that deafness is not a single experience. This diversity is reflected in how a person becomes deaf, their level of hearing, age of onset, educational background, communication methods, and cultural identity.

Identity and Terminology

How people identify themselves is personal and may reflect their identification with Deaf communities, the degree to which they can hear, or the relative age of onset.

- **d/Deaf**: The lowercase deaf often refers to the audiological condition of not hearing. In contrast, the uppercase Deaf refers to a specific cultural group that often shares a common language, such as American Sign Language (ASL). For many, being culturally Deaf is not a disability to be "fixed," but a core part of their identity.

- **DeafBlind**: This is a unique and often misunderstood population. DeafBlind individuals are deaf or hard of hearing and have either limited vision or are blind. Their communication needs are highly specific, often requiring specialized interpreters who can facilitate tactile/pro-tactile interpretation or close visual interpretation.

- **DeafPlus**: An umbrella term used to describe individuals who are d/Deaf or hard of hearing and have one or more additional disabilities or medical conditions.

- **Hard of hearing**: This term generally applies to individuals who may benefit from hearing aids or cochlear implants and communicate using spoken language, ASL, or a combination of both.

- **Late-deafened**: This term refers to individuals who became deaf later in life.

When describing someone with acquired hearing loss, using the term "**hearing loss**" is appropriate, as it accurately reflects a change in their hearing levels from a previous state.
It is vital to avoid outdated and offensive terms like "hearing impaired," "deaf-mute," and "deaf and dumb." These terms are often viewed as derogatory because they focus on a perceived deficiency, rather than acknowledging the individual's identity and capabilities. Healthcare professionals should be aware of these nuances and practice cultural humility by using the most commonly accepted terms: d/Deaf, DeafBlind, and hard of hearing.

Prioritizing Communication Accessibility

Each individual has their own communication needs and preferences, which may change from one situation to the next. It is recommended that individuals are put in the driver's seat of their communication experience. This means you should always start by asking the individual, "How can I best communicate with you?"

Their preferred methods may include:

- **In-person Interpreting:** Using a qualified professional on-site, including ASL interpreters, Certified Deaf Interpreters (CDIs) for complex linguistic needs, or tactile interpreters for DeafBlind individuals.
- **Video Remote Interpreting (VRI):** A video conferencing service that connects an off-site interpreter to the patient and provider via a tablet or monitor.
- **Communication Access Real-time Translation (CART):** The instant translation of the spoken word into English text, displayed on a monitor or mobile device (often preferred by those who do not use sign language).
- **Using hearing aids or cochlear implants:** Utilizing the patient's own hearing aids or cochlear implants.
- **Lipreading:** Relying on visual cues from the speaker's mouth and face. There are limitations with this method as it is often exhausting and only 30% of English is visible on the lips.
- **Written Communication:** Writing or typing back and forth. This is useful for brief, simple interactions but often inappropriate for complex medical discussions or for those whose primary language is ASL.

By using this approach, you ensure effective and respectful communication that honors their unique needs and identity. We'll discuss each of the communication methods in further detail throughout the toolkit.

Barriers to Care

DDBHH individuals face significant barriers in healthcare that often lead to health disparities. These include:

- **Communication Gaps**: Communication is at the heart of the provider-patient relationship. When there is a communication breakdown, patients may not be able to fully describe their symptoms, understand a diagnosis, or comprehend treatment plans. This can result in lower rates of preventative care, higher rates of chronic disease, and poorer health outcomes.

- **Misconceptions and Unconscious Bias**: Many people hold misconceptions about Deaf and hard of hearing people, assuming that all Deaf people use ASL, can lipread, or are not as intelligent as hearing people. These misconceptions can lead to communication barriers and misunderstandings. It's important to remember that not all Deaf people can speak, and a person's English proficiency is not a measure of their intelligence.

- **Limitations of Video Remote Interpreting (VRI)**: While VRI is a valuable tool, it is not always an effective substitute for an in-person interpreter. VRI may not be appropriate in situations where a patient's condition is serious or unstable, they have physical or cognitive limitations, or the discussion involves complex, high-risk topics like informed consent or end-of-life care. Technology-related issues, such as a poor connection or a blurry image, can also create a barrier to effective communication.

- **Limitations with Telehealth**: While telehealth offers a convenient way to access care, it can present unique challenges for DDBHH patients, especially with communication. There can be difficulty with integrating third-party interpreters and captioning services into a secure telehealth platform that can lead to delays or prevent access to essential services due to technical or privacy concerns. Furthermore, for DeafBlind patients, the absence of a tactile interpreter makes telehealth a poor substitute for in-person care.

- **Inappropriate Terminology**: The use of outdated or offensive terms can be a barrier to care. The most acceptable terms are "d/Deaf," "DeafBlind" and "hard of hearing". Using respectful and accurate terminology is crucial for respectful communication.

- **Workforce and Resource Constraints:** The nationwide shortage of qualified ASL interpreters and Certified Deaf Interpreters (CDIs) creates significant access challenges, particularly in rural and underserved areas. Long wait times, limited after-hours availability, and competition for qualified interpreters can result in patients receiving suboptimal communication support.

Laws & Legal Requirements

Illinois hospitals must comply with a combination of federal and state laws and regulations that ensure effective communication and nondiscrimination for patients with language or communication barriers.

The contents of this section are provided for **informational purposes** only, based on legal standards as of February 2026. It is not intended as legal advice. Laws may change and **hospitals and health systems should consult their legal counsel regarding the application of these laws to their specific circumstances**.

Federal Requirements

Hospitals in Illinois must adhere to federal laws that protect individuals with disabilities and those with limited English proficiency.

- **Americans with Disabilities Act of 1990 (ADA):** The ADA is a federal civil rights law that protects qualified individuals with disabilities from discrimination on the basis of their disability. Under the ADA, healthcare providers must give people with disabilities full and equal access to healthcare services and facilities. This includes ensuring that written and spoken communication is as clear and understandable to people with disabilities as it is to those without. Providers must offer effective communication, whether through interpreting services or other auxiliary aids and services, free of charge to the patient, companion, or patient representative.

- **Section 1557 of the Affordable Care Act (ACA):** Section 1557 is the civil rights provision of the ACA that prohibits discrimination based on race, color, national origin, sex, age, or disability in certain health programs and activities. This law requires covered entities, such as healthcare providers, to take appropriate steps to ensure that communication with individuals with disabilities is as effective as communication with others. Consistent with ADA Title II regulations, Section 1557 also requires these entities to give "primary consideration" to an individual's requested communication accommodation. This means caregivers should inquire about a patient's choice of auxiliary aid or service and honor it, unless another equally effective means of communication can be demonstrated. The law also specifies that a staff member's self-identification as bilingual is not sufficient to establish bilingual proficiency and a healthcare provider cannot require a family member or friend to interpret for a patient, though in an emergency or if specifically requested by the patient, a family member or friend may assist if they agree to do so and it is appropriate under the circumstances.

- **Section 504 of the Rehabilitation Act of 1973:** Section 504 is a federal law that prohibits discrimination based on disability. The law applies to programs and activities that receive federal financial assistance from any federal department or agency, including the U.S. Department of Health and Human Services (HHS). Under Section 504, recipients of this funding, such as hospitals, must ensure that individuals with disabilities have an equal opportunity to participate in or benefit from programs or activities. To achieve this, the law requires providers to ensure effective communication with individuals who have hearing, vision, and speech disabilities. This is done by providing auxiliary aids and

services, such as qualified interpreters or readers, assistive listening devices or systems, text telephones, and information in formats like Braille or large print, all free of charge to the patient.

Illinois State Requirements

In addition to federal laws, Illinois has its own statutes and regulations that mandate language and communication assistance in healthcare facilities.

- **The Illinois Language Assistance Services Act (210 ILCS 87/):** This Act requires health facilities to provide access to healthcare information and services for patients who are deaf or have limited English proficiency. Under this Act, hospitals must adopt and annually review a policy for providing language assistance services that includes procedures to ensure interpreters are available 24 hours a day, either on-site or by telephone, to maximize efficiency and minimize delays. Hospitals are required to submit their updated policy to the Illinois Department of Public Health (IDPH) each year. They must also create and post notices in public areas, such as the emergency room, admitting area, and main entrance, to inform patients about interpreter availability, how to get one, and how to file a complaint with IDPH, which is responsible for the complaint system for violations of the Act. Additionally, the Act encourages facilities to document a patient's primary language in their medical chart, hospital bracelet, bedside notice, or nursing card and maintain a list of proficient interpreters for both sign language and common spoken languages. The Act prohibits hospitals from requiring a family member or friend to interpret, but a patient may choose to use a family member or friend after being informed of the available interpreter services, provided this choice is documented in the patient's chart.

- **The Interpreter for the Deaf Licensure Act of 2007 (225 ILCS 443):** This Act protects the public by setting standards for interpreters and ensuring only qualified individuals practice the profession. For healthcare facilities, this means that any sign language interpreter hired or contracted to provide services must be licensed by the state, unless an exemption applies (e.g., emergency treatment situations). This licensure requirement applies regardless of whether the interpreter is physically on-site or providing services remotely via video interpreting platforms, ensuring a consistent standard of communication and care for all DDBHH patients.

Guidelines and Positions

The following resources and guidelines can help healthcare organizations improve patient safety and satisfaction, ensure legal compliance, and ultimately provide more equitable and effective care for the DDBHH community:

- [U.S. Department of Justice (DOJ) ADA Business Brief: Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings]: A clear, concise guide from the DOJ on how hospitals can meet their legal obligation to ensure effective communication with DDBHH patients under the ADA.

- [The Joint Commission 2026 National Performance Goals]: The Joint Commission's 2026 National Performance Goals (effective January 1, 2026) formally embed language access into patient safety accreditation. Goals 4 and 7 require patients receive information in a language and format they understand and that hospitals stratify quality data by preferred language. Additional goals impact language access across patient identification (Goal 1), safety culture and grievance accessibility (Goal 2), emergency management multilingual protocols (Goal 3), medication safety and discharge comprehension (Goals 6 and 14), suicide risk screening (Goal 8), and workforce competency for bilingual staff (Goal 12). These standards require hospitals to embed language access into clinical workflows, quality improvement, and staff competency programs.

- [U.S. DOJ Brief: Effective Communication]: A comprehensive DOJ brief that explains the ADA's "effective communication" requirement and the responsibility of entities to provide auxiliary aids and services.

- [Federal Communications Commission (FCC) Final Rule: Telecommunications Relay Services and Speech-to-Speech Services for Individuals with Hearing and Speech Disabilities]: An FCC rule that mandates accessible phone services, ensuring that individuals with auditory and speech differences can effectively communicate with healthcare providers over the phone.

- [National Culturally and Linguistically Appropriate Services (CLAS) Standards]: A set of national standards that provide a framework for healthcare organizations to deliver culturally and linguistically appropriate services, including those for individuals with auditory and speech differences.

- [American Hospital Association (AHA) Publication: Collection and Use of Race, Ethnicity and Language (REAL) Data]: A publication that advocates for the collection of REAL data, including communication needs, to help healthcare organizations identify and address health disparities.

- [National Association of the Deaf (NAD) Position Statement: Minimum Standards for Video Remote Interpreting Services in Medical Settings]: A position statement outlining the minimum standards for VRI to be an effective and appropriate tool for medical communication.

- **HHS, National Institutes of Health (NIH), and the National Institute on Deafness and Other Communication Disorders (NIDCD) Publication: American Sign Language:** A publication providing an overview of ASL as a distinct language, helping healthcare providers better understand Deaf culture and communication.

Auxiliary Aids and Services Overview

Public and private entities are required to provide effective communication for DDBHH individuals to ensure that their communication is as effective as communication with individuals who do not have disabilities.

To achieve this, entities must provide appropriate auxiliary aids and services when needed. The specific aid or service required depends on several factors, including:

- The nature, length, and complexity of the communication;
- The individual's preferred method of communication; and
- The context of the communication (e.g., a simple transaction vs. a complex medical consultation).

As there is no one-size-fits-all approach to communicating with DDBHH individuals, a comprehensive approach is needed to ensure effective communication involves access to a range of auxiliary aids and services tailored to a patient's specific needs and preferences. The following are recommended auxiliary aids and services that hospitals can and should consider using to ensure effective communication, moving beyond the most common tools to a wider array of options.

Commonly Used Aids and Services

- **In-Person Sign Language Interpreters:** An on-site interpreter who facilitates real-time, face-to-face communication between a patient and a provider. Utilization of these individuals is the best practice for longer, complex, or sensitive appointments, such as surgical consultations, mental health counseling, or end-of-life discussions, as they help build rapport and convey subtle nuances.

- **Video Remote Interpreting (VRI):** VRI uses a secure, high-quality video system to connect patients and providers with a remote interpreter. It is a versatile tool for a variety of situations, especially shorter appointments, check-ins, or emergencies where an on-site interpreter is not immediately available. The use of VRI may be limited by factors like the patient's visual acuity, cognitive abilities, and the complexity or sensitivity of the subject matter.

Lesser-Known Aids and Services

A comprehensive toolkit includes a variety of auxiliary aids to meet the diverse communication needs of patients.

- **Communication Access Real-Time Translation (CART):** CART provides live captions of spoken conversation. This is an excellent option for individuals who do not use sign language or have varying hearing levels and benefit from a written transcript of conversations. CART and AI captions are different. CART relies on a human stenographer for highly accurate, contextual transcription. In contrast, AI captioning is an automated process that is scalable but may lack the accuracy and nuance of a human-provided service.

  When using CART, it is critical to ascertain HIPAA compliance, especially when dealing with Protected Health Information (PHI), as not all transcription services, particularly automated ones, are compliant without a signed Business Associate Agreement (BAA). Organizations considering AI-powered captioning or interpreting tools should establish governance frameworks addressing: accuracy thresholds (AI should not be the sole method for high-risk clinical discussions); HIPAA compliance requiring a signed BAA with any AI vendor processing PHI; patient consent for AI-assisted communication; regular quality audits benchmarking AI against human interpreters; and clear escalation paths to human interpreters when AI is insufficient. AI tools may supplement communication (ambient captioning) but should not replace qualified human interpreters for clinical decision-making.

- **Assistive Listening Devices (ALDs):** Devices such as voice amplifiers and pocket talkers that amplify sound to help patients who need an increased volume to understand speech.

- **Visual Alert System:** Provides visual or vibrating alerts to notify Deaf or hard of hearing individuals of someone entering a room and daily sounds like phones, door knocks, and alarms.

- **Clear View Masks:** Masks with a transparent window allowing individuals to see the speaker's mouth and facial expressions.

- **Whiteboards or Dry Erase Boards:** Useful tools for quickly writing out questions, answers, or key information, particularly when an interpreter is not available or for brief interactions.

- **Picture Boards:** Picture boards use a series of images or symbols to represent common concepts, actions, or objects, allowing for basic communication and the expression of needs. They are a valuable resource for conveying essential information when other communication methods are not feasible.

- **Universal Signage:** A sign that can be placed outside of a room to indicate that a patient requires an interpreter and/or other auxiliary aids/services.

- **Sight Translation of Vital Documents:** Translating vital documents into ASL is crucial for effective communication and accessibility. Vital documents are those that contain information critical for accessing services or understanding rights, such as consent forms, discharge instructions, billing notices, and privacy policies. These documents should be accurately translated into the individual's primary language to ensure they can make informed decisions, understand their care, and navigate the system without language being a barrier. Providing translated materials is a key part of ensuring equitable access for individuals with limited English proficiency.

- **Reformatted Documents:** Providing documents in large print, change in paper color, or Braille can assist individuals with low vision, including those who are DeafBlind or are Deaf and hard of hearing with low vision. Reformatting into large print can be done for patients with low vision or acute vision loss, especially when they do not have their glasses or contacts.

- **Telephone-Based Auxiliary Aids:** The appropriate telephonic device is contingent on the individual's specific communication needs and preferences:

    - **Amplified Telephones:** These phones are designed with built-in amplification to increase the volume of incoming calls, making them easier to hear. Some models also have adjustable tone controls to customize the sound.

    - **Caption Telephones:** These phones display written captions of the conversation on a screen, allowing users to read what the other person is saying in real-time. They are particularly useful for individuals with some residual hearing who may struggle to understand spoken words alone.

    - **Videophones:** A videophone allows a person to make and receive calls using sign language. It transmits a live video feed, enabling visual communication between individuals who are deaf or hard of hearing and a sign language interpreter or another videophone user. Video Relay Service (VRS) is an example of a service used with a videophone, where a sign language interpreter facilitates the call between a deaf person and a hearing person.

- **Teletypewriter (TTY):** While not as common as using a videophone, a TTY is a device that allows a person to type and send text messages over a standard telephone line. The receiving party must also have a TTY or use a relay service to convert the text to speech.

The key to ensuring equitable and effective communication is for entities to have a comprehensive understanding of and access to a full range of auxiliary aids and services, ready to be customized for each individual.

Suggested Standards for Implementation

Effective communication is not just about having the right tools but also about having the right policies and standards for their use. A comprehensive set of policies and standards is essential to ensure proper use of effective communication tools like VRI.

Below are suggested standards for the use of VRI, CDIs, and telehealth with the DDBHH community.

Video Remote Interpreting (VRI) Implementation Standards

VRI is a powerful tool, but its effectiveness depends on proper implementation. Suggested standards include:

- **Technical Requirements:** To ensure a high-quality, lag-free experience, a hospital's VRI setup should meet specific technical standards. This includes a stable, high-speed internet connection, high-definition cameras, and clear audio transmission. The video feed must be large enough to clearly show the interpreter's face, hands, and arms.

- **When to Use VRI:** VRI is a common solution in emergent situations where an in-person interpreter is not immediately available. If a scheduled interpreter is delayed, caregivers should continue to offer VRI or other communication methods.

- **When NOT to use VRI:** VRI may not be appropriate in certain situations, including:

    - When the individual does not consent to its use.
    - When the patient's condition is serious, unstable, or if they have limited mobility, vision, or focus.
    - If the individual's emotional state, cognitive issues, or level of pain impacts their ability to communicate.
    - For minors, or when there are multiple people present.
    - For high-risk or sensitive discussions, such as informed consent, surgery, or end-of-life considerations.

- If VRI is not providing effective communication, personnel should terminate its use and obtain an on-site interpreter.

Telehealth Implementation Standards

The effectiveness of telehealth for the DDBHH community depends on specific technical and clinical configurations that mirror the quality of an in-person encounter.

- **Technical and Display Requirements:**
    - **Mandatory Integrated Services:** Telehealth platforms must provide both real-time captioning (CART) and sign language interpreting simultaneously to meet diverse patient needs.
    - **Landscape Orientation:** To ensure a sufficient field of vision, video feeds must be viewed in landscape (horizontal) orientation rather than vertical. This is necessary to clearly capture the interpreter's facial expressions, hands, and full range of arm movements, which are essential for linguistic accuracy.
    - **High-Definition Video:** Use high-definition cameras and a stable, high-speed connection to prevent "freezing" or lagging, which can cause critical communication breakdowns during medical discussions.
- **Clinical Considerations (When NOT to use Telehealth):**
    - **Ineffective Technology:** If the platform cannot support simultaneous captioning and interpreting, or if the connection remains unstable, the session must be terminated in favor of an in-person appointment.
    - **Lack of Consent:** Telehealth should not be used if the patient does not consent to remote care or feels it is not an effective way for them to communicate their medical needs.
    - **High-Risk Discussions:** Remote care may be inappropriate for complex, high-stakes conversations such as informed consent for surgery, end-of-life planning, or highly emotional mental health crises.
    - **Physical or Cognitive Barriers:** Telehealth is often a poor substitute for patients with limited vision (DeafBlind), acute pain, or cognitive disabilities that make screen-based focus difficult.

Certified Deaf Interpreters (CDIs) Standards

A CDI is a specialist who is Deaf and has native or near-native fluency in ASL. CDIs work in tandem with hearing interpreters to ensure that communication is as effective as possible. A CDI can be particularly beneficial in several situations:

- **Patients with Varying Language Skills:** A CDI is essential for communicating with children, individuals who may have cognitive disabilities, those with limited language acquisition, or individuals who are not fluent in a standard sign language, including ASL.
- **Culturally Sensitive Conversations:** CDIs can navigate cultural and linguistic nuances that a hearing interpreter may miss.
- **High-Stakes Situations:** A CDI's presence is often necessary for sensitive or highly emotional conversations, such as those related to mental health crises, trauma, or abuse.

Telehealth Standards

Telehealth is an increasingly important part of healthcare, and it must be accessible. Best practices include:

- **Platform Compatibility:** Ensuring that telehealth platforms are compatible with sign language interpreters and real-time captioning.
- **Staff Training:** Training staff to use these tools effectively during remote appointments and secure sign language interpreters and real-time captioning as requested.
- **Pre-Appointment Instructions:** Providing patients with pre-appointment instructions and technical support to ensure a smooth, accessible experience.

Bilingual Staff Communication Standards

Healthcare facilities employing bilingual staff who communicate with DDBHH patients must follow best practices. An example includes alignment with the Joint Commission 2026 National Performance Goal #12 to:

- Validate medical linguistic competency through documented assessments (conversational fluency alone is insufficient);
- Distinguish between direct bilingual communication (no certification required) and interpreter-mediated communication between provider and patient (requires validated competency); and

- Document the use of bilingual staff and their validated competency in the patient medical record.

Emergency Management Communication Standards

Effective emergency response for healthcare entities integrates standards for communication. Healthcare facilities should integrate best practices for communication into their emergency management programs. An example would include alignment with the Joint Commission 2026 National Performance Goal #3 to:

- Integrate multilingual and visual alert protocols into emergency notification systems;
- Pre-establish access to qualified ASL interpreters in emergency drills and response plans (not improvised during events);
- Implement patient room signage and EHR flags for rapid identification of communication needs during evacuations; and
- Regularly test emergency communication protocols with DDBHH scenarios included in drills.

Assessing and Reassessing Communication Effectiveness

Policies should include clear requirements for assessing and reassessing the effectiveness of communication tools. This is not a one-time process; it is an ongoing effort to ensure patient safety and effective care.

- **Initial Assessment:** Before using any communication tool, a healthcare provider should conduct a brief initial assessment to determine if it is the most appropriate method. This assessment should consider the patient's condition, emotional state, mobility, and the complexity or sensitivity of the topic being discussed. For example, a patient with limited vision or mobility may not be able to effectively use a video-based tool, and a more suitable alternative should be provided.

- **Continuous Reassessment:** The communication method should be reassessed throughout the encounter. If the chosen method is not facilitating effective communication, it should be terminated and an alternative aid/service should be obtained in consultation with the patient/companion.

- **Documenting Communication Method:** All assessments and reassessments of communication methods, including the reason for using or not using a particular tool, must be documented in the patient's medical record. Documentation should be integrated into the EHR system capturing: the patient's preferred communication method and language; the specific auxiliary aid or service provided; the interpreter's name, credentials, and modality; any changes during the encounter and reasons; and

the communication effectiveness assessment outcome. This supports handoff continuity and provides the data infrastructure for language-stratified quality reporting.

- **Patient Consent:** Patient consent for the use of any communication tool is not a one-time thing. The healthcare provider must confirm the patient's continued consent to its use throughout the encounter, especially if the situation becomes more complex or sensitive.

Recommended Training

To support the effective rollout of comprehensive auxiliary aids and services and patient-centered care, we recommend supplementing this toolkit with training that covers the following:

- Identifying the care team's responsibilities to ensure effective communication with a DDBHH patient, companion or visitor.
- Identifying and securing aids, services, and equipment available to assist individuals with communication barriers, as well as the potential limitations of specific accommodations.
- Identifying who can serve as an interpreter.
- Explaining legal requirements and proper documentation standards for communication services.
- Describing how to document interpreter and assistive device preferences and use in your electronic medical record.
- Conducting and documenting communication assessments and reassessments.
- Mitigating individual and systemic biases that affect patient care (e.g., assumptions that lipreading and using paper and pen result in effective communication).
- Using plain language and the "teach-back" method to ensure patient understanding.
- Following best practices for working with interpreters and leveraging non-verbal communication.
- Collaborating as a care team to meet a patient's communication needs during handoffs and throughout their care journey.
- Responding to DDBHH communication needs during emergencies and rapid response.
- Bilingual staff vs. interpreter-mediated communication, including competency validation requirements.
- Appropriate use and limitations of AI communication tools in clinical settings.
- Integrating communication documentation into EHR workflows and handoff protocols.

Measuring Effectiveness

For organizations to measure effectiveness of their programs, recommended items to track include:

- Interpreter response time by modality;
- DDBHH patient satisfaction scores vs. general population;
- Communication-related adverse events or near-misses;
- Readmission rates stratified by communication method;
- Percentage of encounters with documented communication assessments;
- Interpreter utilization by department, modality, and time of day;
- Staff training completion rates; and
- Communication access complaint data.

It is recommended to review metrics quarterly and report to organizational leadership for continuous improvement and JC accreditation readiness.

Additional Support Resources

- Chicago Hearing Society: A non-profit organization that provides comprehensive services, including sign language interpreting, audiologic care, and community advocacy to foster communication and accessibility.

- EmergencyAccess.Info: A collection of accessible resources for DDBHH individuals during emergencies.

- Illinois Department of Human Services Mental Health Services: A summary of mental health services for people who are DDBHH and late-deafened.

- State of Illinois Deaf and Hard of Hearing Commission: State commission that advocates for and promotes legal requirements to ensure effective communication for DDBHH individuals in Illinois.

Conclusion

This toolkit was created to provide hospitals and healthcare systems with a comprehensive framework to enhance care and ensure legal compliance for DDBHH patients. By addressing knowledge gaps, promoting cultural competence, and implementing effective communication strategies, organizations can break down the systemic barriers that lead to healthcare disparities.

With organizations, such as the Joint Commission, implementing guidance and requirements, language access is shifting to be viewed as a patient safety requirement, not simply a patient experience initiative. The guidance within this toolkit positions Illinois hospitals to meet and exceed these evolving expectations. Organizations that invest in comprehensive language

access programs will see benefits in patient outcomes, accreditation readiness, risk reduction, and community trust.

By adopting the standards and best practices outlined here, Illinois hospitals can lead the way in creating a healthcare system that is truly accessible and equitable for all.

We are here to help. Reach out to one of the following contacts for additional support:

IHA
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Phone: 630.246.5400

The Illinois Health and Hospital Association advocates for the more than 200 hospitals and nearly 40 health systems across the state.

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2axend is a Chicagoland based, deaf-owned strategic consulting and training firm that specializes in working with organizations to improve user experiences for their deaf and hard of hearing clients.