



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 1821

Corresponding Measures:

De.2. Measure Title: L2: Patients receiving language services supported by qualified language services providers

Co.1.1. Measure Steward: Department of Health Policy, The George Washington University

De.3. Brief Description of Measure: This measure is used to assess the percentage of limited English-proficient (LEP) patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency.

Interpreter services are frequently provided by untrained individuals, or individuals who have not been assessed for their language proficiency, including family members, friends, and other employees. Research has demonstrated that the likely results of using untrained interpreters or friends, family, and associates are an increase in medical errors, poorer patient-provider communication, and poorer follow-up and adherence to clinical instructions. The measure provides information on the extent to which language services are provided by trained and assessed interpreters or assessed bilingual providers and bilingual workers/employees during critical times in a patient's health care experience.

1b.1. Developer Rationale: Many of the benefits associated with the proposed language services measures are described in a forthcoming article in the Journal of Healthcare Quality (scheduled publication date is March 2012. "Improving the Quality of Language Services Delivery: Findings from A Hospital Quality Improvement Initiative, by Marsha Regenstein, Jenny Huang, Cathy West, Jennifer Trott, Holly Mead and Ellie Andres).

Despite the substantial evidence that supports use of interpreters or bilingual physicians and other health professionals to improve communication, there are no endorsed measures identifying the extent to which health care encounters occur with the use of a trained interpreter or a qualified bilingual provider. The proposed measure enables health care organizations or individual health professionals to determine whether patients with LEP actually receive language services. It is a patient-level measure, tracking whether the individual patient received language services at assessment and discharge (or at the conclusion of an ambulatory visit, when instructions are rendered and discussed), which are two instances when effective communication is essential.

As described in the prior question, having an interpreter to facilitate communication between patients and health professionals can mitigate many of the disparities in care that LEP patients regularly face. LEP patients who are provided with an interpreter have more preventive and primary care visits and fill more prescriptions, compared to LEP patients who do not use an interpreter. Having an interpreter can level the playing field for LEP patients with diabetes, whose care was found to be better than or equal to care received by non-LEP patients with diabetes. LEP patients who used any interpreter were more likely than English-speaking patients to have had a mammogram over a two-year period. In a study of the impact of interpreter services on low-income LEP patients, the availability of trained interpreters was associated with LEP patients having more office visits and filling more prescriptions, as well as reducing disparities related to flu vaccinations and fecal occult blood testing. Patients with language barriers indicated higher levels of satisfaction with care when interpreters were used. Physicians who had access to the services of trained interpreters reported a significantly higher quality of patient-physician communication than physicians without these services.

S.4. Numerator Statement: The number of limited English-proficient (LEP) patients with documentation they received the initial assessment and discharge instructions supported by trained and assessed interpreters, or from bilingual providers and bilingual workers/employees assessed for language proficiency.

Note: The determination of "qualified (assessed and trained)" is consistent with guidance provided by The Joint Commission, The Office of Minority Health CLAS standards; and the Office of Civil Rights.

Citations: The Joint Commission (2011), Patient-Centered Communication Standards for Hospitals, Standard HR.01.02.01; available at http://www.jointcommission.org/Advancing_Effective_Communication/

65 Fed. Reg. 80865 (Dec. 22, 2000) (Department of Health and Human Services: National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care); available at <http://www.omhrc.gov/clas>

65 Fed. Reg. 52762 (Aug. 30, 2000) (Office for Civil Rights: Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency); available at <http://www.hhs.gov/ocr/lep/preamble.html>

S.7. Denominator Statement: Total number of patients that stated a preference to receive their spoken health care in a language other than English.

S.10. Denominator Exclusions: Exclusions:

- All patients stating a preference to receive spoken health care in English.
- Patients who leave without being seen.
- Patients who leave against medical advice prior to the initial assessment.

De.1. Measure Type: Process

S.23. Data Source: Electronic Health Records, Management Data, Other, Paper Records

S.26. Level of Analysis: Clinician : Group/Practice, Facility

IF Endorsement Maintenance – Original Endorsement Date: Aug 09, 2012 **Most Recent Endorsement Date:** Aug 09, 2012

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form
[1821_Evidence_MSF5.0_Data.doc](#)

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

Many of the benefits associated with the proposed language services measures are described in a forthcoming article in the Journal of Healthcare Quality (scheduled publication date is March 2012. "Improving the Quality of Language Services Delivery: Findings from A Hospital Quality Improvement Initiative, by Marsha Regenstein, Jenny Huang, Cathy West, Jennifer Trott, Holly Mead and Ellie Andres).

Despite the substantial evidence that supports use of interpreters or bilingual physicians and other health professionals to improve communication, there are no endorsed measures identifying the extent to which health care encounters occur with the use of a trained interpreter or a qualified bilingual provider. The proposed measure enables health care organizations or individual health professionals to determine whether patients with LEP actually receive language services. It is a patient-level measure, tracking whether the individual patient received language services at assessment and discharge (or at the conclusion of an ambulatory visit, when instructions are rendered and discussed), which are two instances when effective communication is essential.

As described in the prior question, having an interpreter to facilitate communication between patients and health professionals can

mitigate many of the disparities in care that LEP patients regularly face. LEP patients who are provided with an interpreter have more preventive and primary care visits and fill more prescriptions, compared to LEP patients who do not use an interpreter. Having an interpreter can level the playing field for LEP patients with diabetes, whose care was found to be better than or equal to care received by non-LEP patients with diabetes. LEP patients who used any interpreter were more likely than English-speaking patients to have had a mammogram over a two-year period. In a study of the impact of interpreter services on low-income LEP patients, the availability of trained interpreters was associated with LEP patients having more office visits and filling more prescriptions, as well as reducing disparities related to flu vaccinations and fecal occult blood testing. Patients with language barriers indicated higher levels of satisfaction with care when interpreters were used. Physicians who had access to the services of trained interpreters reported a significantly higher quality of patient-physician communication than physicians without these services.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

Substantial evidence suggests that individuals with LEP have difficulties accessing health services (1); when they do receive care it is of lower quality relative to English-speaking patients (2). LEP is itself a risk factor for poor health care access, resulting in challenges obtaining health insurance and completing necessary processes associated with obtaining and maintaining coverage (3-4). Individuals with LEP are less likely to have a regular source of primary care (5) and receive fewer preventive services such as mammograms (6-7). With less prevention, LEP patients tend to seek care in the emergency department (8) and are admitted to the hospital at higher rates (9), with longer lengths of stay (10), compared to non-LEP patients. Not surprisingly, patients with LEP are also at higher risk of medical errors (11-13).

Discordant communication between patients and physicians takes a toll on satisfaction from all affected parties. LEP patients are more likely to report lower satisfaction with the quality of the care they receive and the health professionals with whom they interact, making them less inclined to comply with recommended follow-up and treatment (14-15). Physicians and other health professionals also report lower satisfaction and lower-quality patient-provider interaction when caring for LEP patients without an interpreter (16). Physicians who are unable to communicate effectively with their patients often engage in costly practices such as using more diagnostic resources or invasive procedures (17) and overprescribing medications (18).

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

- (1) Jacobs E, Chen A, Karliner LS, Agger-Gupta N, Mutha S. The Need for More Research on Language Barriers in Health Care: A Proposed Research Agenda. *The Milbank Quarterly* 2006;84(1):111-133.
- (2) Deroose JP, Bahney BW, Lurie N, Escarce JJ. Review: Immigrants and health care access, quality and cost. *Medical Care Research and Review* 2009;66:355-408.
- (3) Jang M, E Lee, Woo K. Income, Language and Citizenship Status: Factors Affecting the Health Care Access and Utilization of Chinese Americans. *Health and Social Work* 1998;23(2):136-45.
- (4) Feinberg E, Swartz K, Zaslavsky A, Gardner J, Walker D. Language Proficiency and the Enrollment of Medicaid-Eligible Children in Publicly Funded Health Insurance Programs. *Maternal and Child Health Journal* 2002;6(1):5-18.
- (5) Weinick RM, Krauss NA. Racial and ethnic differences in children's access to care. *Am J Public Health* 2000;90(11):1771-4.
- (6) Woloshin S, Schwartz LM, Katz SJ, et al. Is language a barrier to the use of preventive services? *J Gen Intern Med* 1997;12(8):472-7.
- (7) Bell TS, Branston LK, Newcombe RG, Barton GR. Interventions to improve uptake of breast cancer screening in inner city Cardiff general practices with ethnic minority lists. *Ethnic Health* 1999;4:277-84.
- (8) Manson A. Language concordance as a determinant of patient compliance and emergency room visits in patients with asthma. *Medical Care* 1988; 26:1119-112.
- (9) Lee ED, Rosenberg CR, Sixsmith DM, Pang D, Abularrage J. Does a Physician-Patient Language Difference Increase the Probability of Hospital Admission? *Academic Emergency Medicine* 1998;5(1):86-89.
- (10) John-Baptiste A, Naglie G, Tomlinson G, Alibhai SM, Etchells E, Cheung A, Kapral M, Gold WL, Abram H, Bacchus M, Krahn M. The Effect of English Language Proficiency on Length of Stay and In-Hospital Mortality. *Journal of General Internal Medicine* 2004;19(3):221-28.
- (11) Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, Hardt EJ. Errors in Medical Interpretation and their Potential Clinical Consequences in Pediatric Encounters. *Pediatrics* 2003;111(1):6-14.

- (12) Ghandi TK, Burstin HR, Cook EF, Puopolo AL, Haas JS, Brennan TA, Bates DW. Drug Complications in Outpatients. *Journal of General Internal Medicine* 2000;15:149-54.
- (13) Cohen AL, Rivara F, Marcuse EK, McPhillips H, Davis R. Are language barriers associated with serious medical events in hospitalized pediatric patients? *Pediatrics* 2005;116(3):575-9.
- (14) Andrulis D, Goodman A, Prior C. What a difference an interpreter can make: Health care experiences of uninsured with limited English proficiency. The Access Project, Boston, MA, 2003.
- (15) David RA, Rhee B. The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *Mt Sinai J Med* 1998;Oct/Nov 65(5,6):393-397.
- (16) Hornberger J, Itakura H, Wilson SR. Bridging Language and Cultural Barriers between Physicians and Patients. *Public Health Reports* 1997;112:410-17.
- (17) Hampers LC, Cha S, Gutglass DJ, Binns HJ, Krug SE. Language barriers and resource utilization in a pediatric emergency department. *Pediatrics* 1999;103(6 Pt 1):1253-6.
- (18) Hampers LC, McNulty JE. Professional interpreters and bilingual physicians in a pediatric department: effect on resource utilization. *Archives of Pediatric and Adolescent Medicine* 2002;156(11):1108-13.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

The population group is persons with limited English proficiency. The proposed language measures track quality (through process measures) for persons who require language services and apply to all language/ethnic/racial groups that require these services. In addition to information provided above, a large body of evidence supports the fact that immigrant, non-English speaking populations experience substantial disparities in health and health care (1-2).

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

- (1) U.S. Department of Health and Human Services, National Healthcare Disparities Reports, (Rockville, MD: U.S. Department of Health and Human Services, 2003-2010).
- (2) Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academy Press, 2003.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.

Immigrants comprise a large and growing segment of American society that is disproportionately low-income and uninsured (1-2). Among the immigrant population, barriers to accessible and high-quality health care are only exacerbated for those who do not speak English fluently. In the U.S., 24 million individuals speak English "less than very well" and are said to be limited English proficient (LEP) (3). For this growing segment of the population, poor health status and diminished access to health care are frequent challenges. As members of racial, ethnic or linguistic minorities, persons with LEP experience disproportionately high rates of infectious disease (4) and infant mortality and are more likely to report risk factors for serious and chronic diseases such as diabetes and heart disease (5). Many of the challenges associated with delivering care to LEP populations result from communication barriers inherent in the LEP patient-provider interaction. Patients who speak languages other than English can have difficulties understanding their diagnosis (6) and why they receive particular types of care (7-8). Patients with LEP are particularly

vulnerable to miscommunication when discharged from the emergency department (9-10), and have poorer follow-up after an emergency department visit (11). LEP patients have been shown to have poorer compliance (12) and lower adherence with diabetes (13) and asthma care regimens (14-15) compared to patients who are English speakers; they also have poorer diabetes outcomes (16).

Having an interpreter to facilitate communication between patients and health professionals can mitigate many of the disparities in care that LEP patients regularly face. LEP patients who are provided with an interpreter have more preventive and primary care visits and fill more prescriptions, compared to LEP patients who do not use an interpreter. (17) Having an interpreter can level the playing field for LEP patients with diabetes, whose care was found to be better than or equal to care received by non-LEP patients with diabetes (18). LEP patients who used any interpreter were more likely than English-speaking patients to have had a mammogram over a two-year period (19). In a study of the impact of interpreter services on low-income LEP patients, the availability of trained interpreters was associated with LEP patients having more office visits and filling more prescriptions, as well as reducing disparities related to flu vaccinations and fecal occult blood testing (17). Patients with language barriers indicated higher levels of satisfaction with care when interpreters were used (20). Physicians who had access to the services of trained interpreters reported a significantly higher quality of patient-physician communication than physicians without these services (21).

Medical interpreters can bridge the communication gap between physician and patient (22), yet interactions between patients with LEP and health professionals frequently occur without the services of an interpreter. No published studies estimate the frequency of interpreter use among LEP patients in the health care setting, although there is evidence of substantial underutilization in the emergency department and across ambulatory and inpatient services (6). Federal civil rights legislation (23) requires health care providers that receive any federal funds (including Medicare and Medicaid reimbursement) to provide language access for LEP patients, although federal oversight of the health care industry's compliance with these rules is extremely limited. In practice, LEP patients' access to interpreter services (IS) is variable and unpredictable (24).

Merely having interpreters available in a health care setting does not mean that the patients who need services will receive them (25). Structural, logistical, and financial barriers are just a few of the impediments to effective use of services. Interpreter services require coordination across components of health systems when, for example, physicians or other health professionals schedule interpreters for LEP patients or coordinate physicians' schedules to match LEP patients with bilingual providers. Interpreter services can require equipment such as dual handsets for telephone interpretation that allow the patient and physician to participate in a conversation without passing the telephone back and forth, thereby disrupting the flow of the interaction. In-person and telephone interpreting also entail additional costs.

Perhaps the most substantial barrier to more widespread use of interpreters for LEP patients is the cost of the service. Studies on the marginal costs of interpreters in the health care setting are scarce, as are estimates of the overall "value" that the use of interpreters brings to the health care encounter. Studies estimate the cost of language services to be low relative to other health care costs, approximately \$234-\$279 per patient per year in inpatient and outpatient settings, respectively (26-27). Language services have also been shown to reduce the cost of emergency department care (28).

Health care organizations routinely place patients at risk for poor quality care by turning to untrained individuals to facilitate communication for LEP patients. Health care organizations use an alternative to the trained medical interpreter. The "ad hoc" interpreter is probably the vehicle used most frequently to allow LEP patients to communicate with health professionals. Ad hoc interpreters are not trained interpreters, but rather friends, family members, staff members and other individuals who present with the patient or are called upon to serve in the interpreter role (29). They are untrained in terms of clinical knowledge or appropriate methods to interpret in a health care setting. Their utility comes from being able to converse with the patient in the patient's language as well as having some level of English proficiency. Though ad hoc interpreters appear to be free to the health system, their use is not without its own set of costs, especially in terms of high rates of clinically significant medical errors (22). Ad hoc interpreters can misinterpret or omit questions asked by physicians (30); family members who interpret sometimes leave the patient out of the discussion altogether, instead answering the physician's questions without consulting the patient (31).

Physicians recognize the need for trained interpreters (32) but may opt to move forward with ad hoc interpreters nevertheless. In a study of resident physicians in urban teaching hospitals with excellent interpreter services, residents described a process of risk assessment in which the perceived value of communication was evaluated against their own constraints in terms of the additional time and processes associated with involving a trained interpreter. (33) This process was termed "getting by" and was facilitated by the availability of ad hoc interpreters (generally family members) present with the patient.

1c.4. Citations for data demonstrating high priority provided in 1a.3

- (1) U.S. Bureau of the Census. American Community Survey: language spoken at home (table S1601). 2005.
- (2) Derose JP, Bahney BW, Lurie N, Escarce JJ. Review: Immigrants and health care access, quality and cost. *Medical Care Research and Review* 2009;66:355-408.
- (3) U.S. Census Bureau, Selected Social Characteristics in the United States: 2006-2008. American Community Survey, 2009. Available at <http://factfinder.census.gov>.
- (4) National Center for Health Statistics. Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD. 2011.
- (5) Institute of Medicine. Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press; 2003.
- (6) Baker DW, Parker RM, Williams MV, Coates WC, Pitkin K. Use and Effectiveness of Interpreters in an Emergency Department. *Journal of the American Medical Association* 1996;275(10):783-788.
- (7) Cass A, A Lowell, M Christie, PL Snelling, M Flack, B Marrnganyin, I Brown. Sharing the True Stories: Improving Communication between Aboriginal Patients and Healthcare Workers. *Medical Journal of Australia* 2002; 176(10):466-70.
- (8) Crane JA. Patient Comprehension of Doctor-Patient Communication on Discharge from the Emergency Department. *Journal of Emergency Medicine* 1997; 15(1):1-7.
- (9) Shapiro J, Saltzer E. Cross-Cultural Aspects of Physician-Patient Communications Patterns. *Urban Health* 1981; (December):10-15.
- (10) Kazzi Bonacruz G, Cooper C. Barriers to the Use of Interpreters in Emergency Room Paediatric Consultations. *Journal of Paediatric Child Health* 2003; 39(4):259-63.
- (11) Sarver J, Baker DW. Effect of Language Barriers on Follow-up Appointments after an Emergency Department Visit. *Journal of General Internal Medicine* 2000; 15(4):256-64.
- (12) Ku L, Waidman T. How race/ethnicity, immigration status and language affect health insurance coverage, access to care and quality of care among the low-income population. Final Report. Washington, DC: Kaiser Family Foundation, Publication #4132, 2003.
- (13) Karter AJ, Ferrara J, Darbinian LM, Ackerson, JV Selby. Self-monitoring of blood glucose: Language and financial barriers in a managed care population with diabetes. *Diabetes Care* 2000;23(4):477-83.
- (14) Manson A. Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. *Medical Care* 1988;26(12):1119-28.
- (15) Apter AJ, Reisine ST, Afflect G, Barrows E, ZuWallack RI. Adherence with twice daily dosing of inhaled steroids. *American Journal of Respiratory and Critical Care Medicine* 1988;157:1810-17.
- (16) Lasater LM, Davidson AF, Steiner JF, Mehler PS. Glycemic control in English- vs. Spanish-speaking Hispanic patients with Type 2 Diabetes Mellitus. *Archives of Internal Medicine* 2001;161:77-82.
- (17) Jacobs EA, Lauderdale DS, Meltzer D, Shorey JM, Levinson W, Thisted RA. Impact of interpreter services on delivery of health care to limited-English proficient patients. *Journal of General Internal Medicine* 2001;16:468-74.
- (18) Tocher TM, Larson E. Quality of diabetes care for non-English-speaking patients. A comparative study. *Western Journal of Medicine* 1998;168:504-11.
- (19) David RA, Rhee B. The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *Mt Sinai J Med* 1998;Oct/Nov 65(5,6):393-397.
- (20) Kuo D, Fagan MJ. Satisfaction with methods of Spanish interpretation in an ambulatory care clinic. *Journal of General Internal Medicine* 1999;14(9):457-50.
- (21) Hornberger JC, Gibson CD, Wood W, Dequeldre C, Corso I, Palla B, Bloch DA. Eliminating language barriers for non-English-speaking patients. *Medical Care* 1996;34:845-56.
- (22) Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, Hardt EJ. Errors in Medical Interpretation and their Potential Clinical Consequences in Pediatric Encounters. *Pediatrics* 2003;111(1):6-14.
- (23) Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d); 65 FR 50121, August 16, 2000.
- (24) Flores G, Torres S, Holmes LJ, Salas-Lopez D, Youdelman MK, Tomany-Korman SC. Access to hospital interpreter services for limited English proficient patients in New Jersey: a statewide evaluation. *J Health Care Poor Underserved* 2008;19(2):391-415.
- (25) Regenstien M. Measuring and improving the quality of hospital language services: insights from the Speaking Together collaborative. *JGIM* 2007;22 Suppl 2:356-9.
- (26) Jacobs EA, Shepard DS, Suaya JA, Stone E. Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services. *American Journal of Public Health* 2004; 94(5):866-69.
- (27) Jacobs EA, Sadowski L, Rathouz PJ. The Impact of an Enhanced Interpreter Service Intervention on Hospital Costs and Patient Satisfaction. *Journal of General Internal Medicine*. 2007; 22(Suppl 2): 306-311.
- (28) Hampers LC, McNulty JE. Professional interpreters and bilingual physicians in a pediatric department: effect on resource

utilization. Archives of Pediatric and Adolescent Medicine 2002;156(11):1108-13.
 (29) Leanza Y, Boivin I, Rosenberg E. Interruptions and resistance: a comparison of medical consultations with family and trained interpreters. Soc Sci Med. 2010;70(12):1888-95.
 (30) Ebdin P, OJ Carey, Bhatt A, Harrison B. The bilingual consultation. Lancet 1988;1:347.
 (31) Marcos LR. Effects of interpreters on the evaluation of psychopathology in non-English-speaking patients. American Journal of Psychiatry 1979;136:171-74.
 (32) Leman P. Interpreter use in an inner city accident and emergency department. Journal of Accident and Emergency Medicine 1997;14:98-100.
 (33) Diamond LC, Schenker Y, Curry L, Bradley EH, Fernandez A. Getting By: Underuse of Interpreters by Resident Physicians. Journal of General Internal Medicine 2008;24(2):256-62.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific (check all the areas that apply):

Disparities Sensitive, Safety

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)
http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3870218A-5056-9D20-3D6DA9069C41BB77.pdf

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

URL Attachment:

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)
IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

The number of limited English-proficient (LEP) patients with documentation they received the initial assessment and discharge instructions supported by trained and assessed interpreters, or from bilingual providers and bilingual workers/employees assessed for language proficiency.

Note: The determination of "qualified (assessed and trained)" is consistent with guidance provided by The Joint Commission, The Office of Minority Health CLAS standards; and the Office of Civil Rights.

Citations: The Joint Commission (2011), Patient-Centered Communication Standards for Hospitals, Standard HR.01.02.01; available at [http://www.jointcommission.org/Advancing_Effective Communication/](http://www.jointcommission.org/Advancing_Effective_Communication/)

65 Fed. Reg. 80865 (Dec. 22, 2000) (Department of Health and Human Services: National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care); available at <http://www.omhrc.gov/clas>

65 Fed. Reg. 52762 (Aug. 30, 2000) (Office for Civil Rights: Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency); available at <http://www.hhs.gov/ocr/lep/preamble.html>

S.5. Time Period for Data (*What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.*)

The time window is an encounter or point in time. All cases in the denominator are equally eligible to appear in the numerator

S.6. Numerator Details (*All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b) IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.*

Inclusions: The number of limited English-proficient (LEP) patients with documentation that they received both initial assessment and discharge instructions supported by:

- . *Assessed and trained interpreters; or,
- . Bilingual providers or bilingual workers/employee *assessed for language proficiency.

Exclusions:

- Patients receiving initial assessment and/or discharge instructions supported by interpreters who have not met the organization's *training and assessment requirements.
- Patients receiving initial assessment and/or discharge instructions from a bilingual provider or bilingual worker/employee who has not met the organization's *training and assessment requirements.
- Patients receiving initial assessment and/or discharge instructions supported by family or friends.
- There is no documentation indicating provision of qualified language services provided at initial assessment and/or discharge instructions.

Data Elements:

-Preferred spoken language for health care

-Initial assessment

-Discharge instructions Definitions:

* Note: The determination of "qualified (assessed and trained)" is consistent with guidance provided by The Joint Commission, The Office of Minority Health CLAS standards; and the Office of Civil Rights.

Citations: The Joint Commission (2011), Patient-Centered Communication Standards for Hospitals, Standard HR.01.02.01; available at [http://www.jointcommission.org/Advancing_Effective Communication/](http://www.jointcommission.org/Advancing_Effective_Communication/)

65 Fed. Reg. 80865 (Dec. 22, 2000) (Department of Health and Human Services: National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care); available at <http://www.omhrc.gov/clas>

65 Fed. Reg. 52762 (Aug. 30, 2000) (Office for Civil Rights: Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency); available at <http://www.hhs.gov/ocr/lep/preamble.html>

Definitions:

Preferred spoken language for health care: the preferred language that is stated by the patient for speaking to health care providers.

This includes ASL.

Initial assessment: the first evaluation from a medical doctor, nurse practitioner, or physician assistant (excludes triage, medical assistant, nurse aid).

Discharge instructions: discussion of the instructions with the nurse at the end of a hospital stay or ED visit. The instructions from the medical doctor, nurse, nurse practitioner or physician assistant at the end of an outpatient visit.

Interpreter: an individual whose primary job responsibility is to render a message spoken or signed in one language into a second language without adding, omitting, or distorting meaning or editorializing. Professional interpreters abide by a code of professional ethics and practice what is called, "transparent interpreting". [NCIHC, CHIA, and TCE]

Bilingual provider: a person with proficiency in more than one language, enabling the person to provide services directly to limited-English proficient patients in their non-English language. [NCIHC]

Bilingual worker/employee: an employee who is a proficient speaker of two languages, usually English and a language other than English, who is often called upon to interpret for limited-English proficient patients, but who is usually not trained as a professional interpreter. [NCIHC]

Citations:

CHIA: California Healthcare Interpreters Association. California standards for healthcare interpreters: Ethical principles, protocols, and guidance on roles & intervention. California: 2002 (Second Printing).

NCIHC: National Council on Interpreting in Health Care. The terminology of health care interpreting: A glossary of terms (Working Papers Series, Volume #3). Washington, DC: 2001

TCE: The California Endowment. Language barriers in health care settings: An annotated bibliography of the research literature. Alice Hm Chen, M.D., M.P.H, Editor. California: August 2003.

S.7. Denominator Statement *(Brief, narrative description of the target population being measured)*

Total number of patients that stated a preference to receive their spoken health care in a language other than English.

S.8. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*

Women

S.9. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

Inclusions:

- All patients indicating or stating a preference to receive spoken health care in a language other than English.

Exclusions:

- All patients indicating or stating a preference to receive spoken health care in English.

Data Elements:

Preferred spoken language for health care

Definition:

Preferred spoken language for health care: the preferred language that is stated by the patient for speaking to health care providers. This includes ASL.

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Exclusions:

- All patients stating a preference to receive spoken health care in English.
- Patients who leave without being seen.
- Patients who leave against medical advice prior to the initial assessment.

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

- All patients stating a preference to receive spoken health care in English.
- Patients who leave without being seen.

•Patients who leave against medical advice prior to the initial assessment.

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

Measure can be reported in the aggregate or stratified by preferred language. Data in measure can be used to stratify various disparities-related measures, for example: percent of LEP patients who receive all recommended diabetes care, stratified by receipt of language services.

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

None

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.18. Calculation Algorithm/Measure Logic (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

Data calculated as aggregate numerator and denominator, monthly, stratified by language, declined or unavailable.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

URL

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Measure includes all admissions and visits -- it is not based on a sample or survey.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Electronic Health Records, Management Data, Other, Paper Records

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

If a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Hospitals utilized and modified existing clinical documentation resources to collect data and to produce measure results through all 3 collaborative programs (Speaking Together; AF4Q Language Quality Improvement Collaborative; and the AF4Q Hospital Quality Network's Improving Language Services).

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

URL

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Facility

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Ambulatory Care : Clinic/Urgent Care, Inpatient/Hospital

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

1821_MeasureTesting_MS5.0_Data.doc

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry), Other

If other: Qualifications of persons providing the interpreter service are available through the organizations human resources departments and or language services departments.

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)

Some data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

Organizations have built specific screens and fields to collect the data in existing electronic records and have transferred these new screens and fields when upgrading existing electronic systems. Organizations have used paper methods to collect data variables until electronic methods are available. Knowing whether an LEP patient received interpreted care is a quality of care and patient safety issue where paper collection is warranted until electronic systems are available.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

These are new data collection and not required for any other programs. However, The Joint Commission's recent Patient Provider Communications Standard addresses demonstrating whether a patient's language needs were met during hospitalization. Organizations need to collaborate with clinicians and with information technology departments to create fields for collecting and for generating reports on how measure performance. Organizations report a large amount of time to collect and report the data in the beginning and once systems are in place, minimal time is needed as it is collected / documented during the provision of care.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
Public Reporting	
Regulatory and Accreditation Programs	

<p>Quality Improvement (Internal to the specific organization)</p>	
<p>4a.1. For each CURRENT use, checked above, provide:</p> <ul style="list-style-type: none"> • Name of program and sponsor • Purpose • Geographic area and number and percentage of accountable entities and patients included <p>4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)</p> <p>4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)</p>	
<p>4b. Improvement</p> <p>Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.</p> <p>4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)</p> <p>Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:</p> <ul style="list-style-type: none"> • Progress (trends in performance results, number and percentage of people receiving high-quality healthcare) • Geographic area and number and percentage of accountable entities and patients included <p>4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.</p>	
<p>4c. Unintended Consequences</p> <p>The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).</p> <p>4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.</p> <p>The measure is straightforward and instructions were provided in group settings and 1:1 on the rationale for the measures, specific variables, definitions and calculation of the measure. A detailed specifications manual was created.</p>	
<p>5. Comparison to Related or Competing Measures</p>	
<p>If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.</p>	
<p>5. Relation to Other NQF-endorsed Measures</p>	

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications completely harmonized?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

N/A

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): Department of Health Policy, The George Washington University

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Co.3 Measure Developer if different from Measure Steward: Department of Health Policy, George Washington University School of Public Health and Health Services

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Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role

in measure development.

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Stage 10: Interpreter Measures

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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2006

Ad.3 Month and Year of most recent revision: 08, 2009

Ad.4 What is your frequency for review/update of this measure? [Annual](#)

Ad.5 When is the next scheduled review/update for this measure? [06, 2012](#)

Ad.6 Copyright statement: © 2009 Department of Health Policy, George Washington University School of Public Health and Health Services.

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: The measures were accepted for the NQMC Web site and are at <http://www.qualitymeasures.ahrq.gov/about/inclusion-criteria.aspx>. This NQMC summary was completed by ECRI Institute on May 17, 2010. The information was verified by the measure developer on July 2, 2010.