



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 #: 1824

Corresponding Measures:

De.2. Measure Title: L1A: Screening for preferred spoken language for health care

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 percent of patient visits and admissions where preferred spoken language for health care is screened and recorded.

Hospitals cannot provide adequate and appropriate language services to their patients if they do not create mechanisms to screen for limited English-proficient patients and record patients' preferred spoken language for health care. Standard practices of collecting preferred spoken language for health care would assist hospitals in planning for demand. Access to and availability of patient language preference is critical for providers in planning care. This measure provides information on the extent to which patients are asked about the language they prefer to receive care in and the extent to which this information is recorded.

1b.1. Developer Rationale: Any benefits that flow from providing effective language services, through the use of a trained interpreter or a qualified bilingual provider, first require the identification of need for services. While health care organizations generally have some type of mechanism to recognize a patient who might need an interpreter, few systematically record this information, which creates opportunities for huge gaps in care.

In the Speaking Together project, hospitals generally performed extremely well on the language screening measure. This was an expected finding, because the selection process for participation in Speaking Together favored hospitals that had systems in place to screen for preferred language and capacity for data collection related to the use of language services. Nevertheless, some of the hospitals showed improvement on this measure. At one hospital, at the beginning of the collaborative, 60% of patients were screened for language preference. Through a combination of efforts such as using data to open a discussion with the leaders of registration and scheduling; training staff on the how and why of screening for language needs; programming reminders in the registration and scheduling screens to prompt staff to complete the language field; and using scripts for language screening, the measure increased to over 80%. Overall, the median value for performance on this measure was 94% at the conclusion of the collaborative. Again, we believe this is much higher than what is generally seen at hospitals since the Speaking Together hospitals were selected in part because they already collected this information in their electronic registration systems.

S.4. Numerator Statement: The number of hospital admissions, visits to the emergency department, and outpatient visits where preferred spoken language for health care is screened and recorded

S.7. Denominator Statement: The total number of hospital admissions, visits to the emergency department, and outpatient visits.

S.10. Denominator Exclusions: There are no exclusions. All admissions, visits to the emergency department, and outpatient visits, including:

- Scheduled and unscheduled visits
- Elective, urgent and emergent admissions
- Short stay and observation patients
- Transfers from other facilities

De.1. Measure Type: Process

S.23. Data Source: Claims, 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
[1824_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)

Any benefits that flow from providing effective language services, through the use of a trained interpreter or a qualified bilingual provider, first require the identification of need for services. While health care organizations generally have some type of mechanism to recognize a patient who might need an interpreter, few systematically record this information, which creates opportunities for huge gaps in care.

In the Speaking Together project, hospitals generally performed extremely well on the language screening measure. This was an expected finding, because the selection process for participation in Speaking Together favored hospitals that had systems in place to screen for preferred language and capacity for data collection related to the use of language services. Nevertheless, some of the hospitals showed improvement on this measure. At one hospital, at the beginning of the collaborative, 60% of patients were screened for language preference. Through a combination of efforts such as using data to open a discussion with the leaders of registration and scheduling; training staff on the how and why of screening for language needs; programming reminders in the registration and scheduling screens to prompt staff to complete the language field; and using scripts for language screening, the measure increased to over 80%. Overall, the median value for performance on this measure was 94% at the conclusion of the collaborative. Again, we believe this is much higher than what is generally seen at hospitals since the Speaking Together hospitals were selected in part because they already collected this information in their electronic registration systems.

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.

Two national surveys of hospital practices concerning the collection of language data (1-2) found that about half of hospitals (46.2%-50.2%) collect information on a patient's language. Another national survey of hospitals found that three-quarters of hospitals indicated that they see patients with limited English proficiency (3), with most indicating that they see LEP patients every day.

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) Hasnain-Wynia R, Yonek J, Pierce D, Kang R, Greising C. Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey. Chicago, IL: Health Research and Educational Trust, 2006.

(2) Regenstein M, Sickler D. Race, Ethnicity and Language of Patients: Hospital Practices Regarding Collection of Information to Address Disparities in Health Care. Washington, DC: National Public Health and Hospital Institute, 2006.

(3) Huang J, Ramos C, Jones K, Regenstein M. Talking with Patients: How Hospitals Use Bilingual Clinicians and Staff to Care for

Patients with Language Needs. Washington, DC: George Washington University, 2009.

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 evidence on disparities by race, ethnicity and language and the need for standard data collection has been described extensively (1-2). Most recently, it was summarized by the Institute of Medicine in its report: Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement (3).

The proposed measure responds to many of the issues identified in this report and other evidence on the need for better data to conduct quality improvement and to eliminate health care disparities. The proposed measure, however, is principally designed to identify need for effective language services. It can provide information for quality improvement purposes or to better understand a health care organization's patient population. It is not designed to identify patients by a particular racial or ethnic group. Its purpose is to identify the true demand for language services provided by qualified language services individuals (e.g., trained interpreters, assessed bilingual providers). The IOM guidance includes a question about language proficiency that can be extremely helpful in understanding literacy and related issues. The proposed measure addresses the second question listed by the IOM on language needs to record the spoken language preferred for health care.

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.

(3) Institute of Medicine: Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement. Washington, DC: National Academy Press, 2009.

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.

Critical to providing effective language services is the need to identify those individuals who require such services. Substantial work has been undertaken over the past several years to identify the best ways to collect patient data on race, ethnicity and language. The proposed measure seeks to determine language preference as the principal mechanism to identify need for language services (34-35).

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.
 (34) Institute of Medicine. Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement. Washington, DC: National Academy Press, 2009.
 (35) HRET: Hasnain-Wynia R, Pierce D. HRET Disparities Toolkit: A Toolkit for Collecting Race, Ethnicity and Primary Language Information from Patients: Chicago, IL; The Health Research and Education Trust, 2005.

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 hospital admissions, visits to the emergency department, and outpatient visits where preferred spoken language for health care is screened and recorded

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.)

Time window is a single 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.

Data Elements:

Preferred spoken language for health care

Admissions

Visits

Definitions:

Admissions: a patient health care encounter involving an inpatient stay, whether this is a direct admit to the hospital (scheduled or unscheduled) or occurs through the emergency department.

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

Visit: patient health care encounter with a provider in the hospital emergency department, ambulatory unit or clinic.

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

The total number of hospital admissions, visits to the emergency department, and outpatient visits.

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)

Data Elements:

Admissions

Visits

Definitions:

Admission: a patient health care encounter involving an inpatient stay, whether this is a direct admit to the hospital (scheduled or unscheduled) or occurs through the emergency department.

Visit: patient health care encounter with a provider in the hospital emergency department, ambulatory unit or clinic.

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

There are no exclusions. All admissions, visits to the emergency department, and outpatient visits, including:

- Scheduled and unscheduled visits
- Elective, urgent and emergent admissions
- Short stay and observation patients
- Transfers from other facilities

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)

There are no exclusions. All admissions, visits to the emergency department, and outpatient visits, including:

- Scheduled and unscheduled visits
- Elective, urgent and emergent admissions
- Short stay and observation patients
- Transfers from other facilities

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)

Non-English Speaking Populations can be identified from screening to determine if needed language services were delivered. Clinical performance measures can be stratified by language to examine whether disparities exist among varying language groups.

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 Reported As: Aggregate numerator and denominator, monthly, stratified by language, including English, declined, or unavailable.

Numerator:

- Count the number of patient admissions and/or visits for which preferred spoken language for health care is recorded.
- Apply inclusions and exclusions.
- Stratify by language, including English, declined, or unavailable.

Denominator:

- Count the total number of patient admissions and/or visits.
- Stratify by language, including English, declined, or unavailable.

Notes for Abstraction:

- If patient refused to answer and declined is recorded, credit for screening for preferred spoken language for health care may be taken.
- If electronic systems pre-populate the language preference field, credit for screening for preferred spoken language for health care may be taken for this admission or visit.
- If a space on a document or field in an electronic system for recording language preference for health care is not populated, credit for screening for preferred spoken language for health care may not be taken.
- If the patient's preferred written language for health care information is recorded and the preferred spoken language for health care is not recorded, credit for screening spoken language may not be taken.

Notes:

- All patients should be asked to self-identify their preferred spoken language for health care. The goal is for the patient, not the provider or registration/scheduling staff, to self-identify preferred spoken language for health care.
- Suggested screening question: "What language do you prefer to speak with your doctor or nurse?"
- American Sign Language (ASL) should be included as a preferred spoken language for health care for this measure.
- Organizational policy should specify whose preferred spoken language for health care should be documented for pediatric patients and for incapacitated adults.
- For example, Organizational policy may require that the preferred spoken language for health care for a parent, family member or caregiver is recorded in the event of a minor child or incapacitated adult.
- Some organizations pre-populate fields so that certain data are present at subsequent admissions and/or visits.
- For example, address, phone number, and insurance are often pre-populated. Some organizations also pre-populate language information fields.
- Please note: Organizational policy should specify whether preferred spoken language for health care should be asked at every admission/visit or verified periodically.
- For newborns: if it is for the birth, the newborn is excluded from the denominator. If the newborn is admitted to the hospital from day 1 forward (and the mother is not admitted to the hospital), the newborn is included in the denominator.
- For Emergency Department visits, hospitals should report all visits (i.e., all who come for care) and not just those who are admitted to the hospital.

Declined: a person who is unwilling to choose/provide a language category or cannot identify him/herself with one of the listed languages. This category is an indication that the person did NOT want to respond to the question and should not be asked again during the same visit or during a subsequent visit. [HRET]

Unavailable: a patient who is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Can be called "Unknown," "Unable to complete," or "Other." This category is an indication that the person could not respond to the question and can be asked again during the same visit or during a subsequent visit. [HRET]

HRET: Hasnain-Wynia, R., Pierce, D. HRET disparities toolkit: A toolkit for collecting race, ethnicity, and primary language information from patients. The Health Research and Education Trust. February 2005.

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.

Claims, 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.

Data on language preferences is generally collected at the point of admission, whether as an inpatient, emergency department patient, or ambulatory patient. Some health care organizations use registration systems that are linked with other sources of information; others use electronic health records that include registration/administrative data and clinical data.

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

1824_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.

Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry), Other

If other: Patients asked spoken language preference for health care during registration / scheduling process

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)

ALL data elements are in defined fields in a combination of 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.

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.

The Joint Commission's recent Patient Provider Communications Standard addresses demonstrating identification of a patient's language preference during hospitalization.

Once staffs are educated on self reported language preference for health care and data collection is established as part of the registration staff and scheduling staffs routine, this is a straightforward process. Registration systems do not always have the required fields in place and or the fields that come with the system may not be labeled 'preferred' but most often 'primary' language and these need to be changed by the organization. Organizations also benefit from having lists of the most common languages at the organization for staffs to pick from vs. relying on free text fields where typos occur. Some organizations have made the fields mandatory (cannot bypass) or have implemented pop-ups as reminders to go back and fill in data. Some have policies where once language data are collected; fields are pre-populated and verified at specific points in time so that the questions are not asked at every encounter. Once systems are established, minimal amount of time is required for asking the patients. Most organizations use language identification aids such as cards where patients point to their language.

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	
Quality Improvement (Internal to the	

specific organization)	
--	--

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

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?)

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.)

4b. Improvement

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.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- 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

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.

4c. Unintended Consequences

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).

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.

Some registration staff may assume that the patient's spoken language and written language is the same and not ask for the written language. Education and training on collection of self reported spoken and written language is required at the facility / clinic level. Re-enforcement during training that all patients do not read (even English proficient patients) and that all languages do not have an alphabet have helped to raise an understanding of why this measure alone cannot be used to assume preference for written language. Additionally, for minors and incapacitated adults, organizations are encouraged to set policies to collect the parent or care providers preference until the patient is able. For children it may be necessary to record the language preference of each parent.

5. Comparison to Related or Competing Measures

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>5. Relation to Other NQF-endorsed Measures 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.</p> <p>5.1a. List of related or competing measures (selected from NQF-endorsed measures)</p> <p>5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.</p>
<p>5a. Harmonization The measure specifications are harmonized with related measures; OR The differences in specifications are justified</p> <p>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?</p> <p>5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.</p>
<p>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.</p> <p>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</p>

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
Co.2 Point of Contact: Catherine, West, cathy.west@gwumc.edu, 202-994-8663-
Co.3 Measure Developer if different from Measure Steward: Department of Health Policy, The George Washington University
Co.4 Point of Contact: Catherine, West, cathy.west@gwumc.edu, 202-994-8663-

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.

Measure Contributor List

Lead Developer of Language Services Performance Measures

Marsha Regenstein, Ph.D., M.C.P.

Professor, Department of Health Policy

The George Washington University

Stages 1, 2, 3, 4, and 5: Interpreter Measures

Speaking Together Program Staff

Jennifer Huang, M.S.

Research Scientist

Holly Mead, Ph.D.

Assistant Professor

Marsha Regenstein, Ph.D., M.C.P.

Director, Speaking Together

Jennifer Trott, M.P.H.

Research Associate

Catherine West, M.S., R.N.

Senior Research Scientist

Stage 6: Interpreter Measures

Speaking Together Performance Measures Reviewers and Contributors

Wilma Alvarado-Little

University at Albany, SUNY

Albany, NY

Oscar Arocha, M.M.

Boston Medical Center

Boston, MA

Rochelle Ayala, M.D.

Memorial Healthcare System

Hollywood, FL

Sang-ick Chang, M.D.

San Mateo Medical Center

San Mateo, CA

Lou Hampers, M.D., M.P.H.

The Children's Hospital Denver

Denver, CO

Anita Hunt

Regional Medical Center at Memphis

Memphis, TN

Wendy Jameson

California Health Care Safety Net Institute

Oakland, CA

Bret A. McFarlin, D.O.

Broadlawns Medical Center
Des Moines, IA

Gloria Garcia Orme, RN, MS
San Francisco General Hospital
San Francisco, C.A.

Melinda Paras
CEO, Paras and Associates
Albany, CA

Martine Pierre-Louis, M.P.H.
Harborview Medical Center
Seattle, WA

Angelique Ramirez, M.D.
Parkland Health & Hospital System
Dallas, TX

Cynthia Roat
National Council on Interpreting in Health Care

Matt Wynia, M.D., M.P.H.
American Medical Association

Speaking Together Advisors

Bruce Siegel, M.D., M.P.H.
George Washington University
Washington, DC

Richard A. Wright, M.D., M.P.H., F.A.C.P.E.
Wright Consulting

Stage 7: Interpreter Measures

Speaking Together: Expert Clinicians and Interpreter Service Directors

Oscar Arocha, M.M
Boston Medical Center
Boston, MA

Rochelle Ayala, M.D.
Memorial Healthcare System
Hollywood, FL

Sang-ick Chang, M.D.
San Mateo Medical Center
San Mateo, CA

Anita Hunt
Regional Medical Center at Memphis
Memphis, TN

Bret A. McFarlin, D.O.
Broadlawns Medical Center
Des Moines, IA

Gloria Garcia Orme, RN, MS
San Francisco General Hospital
San Francisco, C.A.

Martine Pierre-Louis, M.P.H.
Harborview Medical Center
Seattle, WA

Angelique Ramirez, M.D.
Parkland Health & Hospital System
Dallas, TX

Stage 10: Interpreter Measures

Language Services Performance Measures: Reviewers and Contributors

Dena Brownstein, MD
Seattle Children's Hospital
Seattle, WA

Maribet McCarty, PhD, RN
Regions Hospital
St. Paul, MN

Kathy Miraglia, MS
University of Rochester Medical Center
Rochester, NY

Sally Moffat, RN
Phoenix Children's Hospital
Phoenix, AZ

Sarah Rafton, MSW
Children's Hospital & Regional Medical Center
Seattle, WA

Loretta Saint-Louis, PhD
Cambridge Health Alliance
Somerville, MA

Sidney Van Dyke, MA
Regions Hospital
St. Paul, MN

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.