

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the [submitting standards web page](#).

NQF #: 1831 NQF Project: Healthcare Disparities Project
(for Endorsement Maintenance Review) Original Endorsement Date: Most Recent Endorsement Date:
BRIEF MEASURE INFORMATION
De.1 Measure Title: L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers
Co.1.1 Measure Steward: Department of Health Policy, The George Washington University
De.2 Brief Description of Measure: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers.
2a1.1 Numerator Statement: The total number of minutes interpreters spent providing interpretation during clinical encounters during the calendar month, stratified by language.
2a1.4 Denominator Statement: The total number of minutes worked by interpreters during the calendar month, stratified by language.
2a1.8 Denominator Exclusions: Exclusions: <ul style="list-style-type: none">• Vacation, sick time, orientation and education leave.• Agency and contract interpreters.• Persons whose primary responsibility is administrative (e.g., interpreter manager, supervisor, director, interpreter department dispatcher, secretary, and scheduler).• Interpreters assigned to non interpreter duties (e.g., shift supervisor, special projects).• Outside vendor telephone interpreters and outside vendor video interpreters.• Bilingual providers and other bilingual hospital workers/employees.
1.1 Measure Type: Process 2a1. 25-26 Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records 2a1.33 Level of Analysis: Clinician : Group/Practice, Facility 1.2-1.4 Is this measure paired with another measure? No De.3 If included in a composite, please identify the composite measure (<i>title and NQF number if endorsed</i>):

STAFF NOTES (<i>issues or questions regarding any criteria</i>)
Comments on Conditions for Consideration:
Is the measure untested? Yes <input type="checkbox"/> No <input type="checkbox"/> If untested, explain how it meets criteria for consideration for time-limited endorsement:
1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (<i>check De.5</i>): 5. Similar/related endorsed or submitted measures (<i>check 5.1</i>): Other Criteria:

Staff Reviewer Name(s):

1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See [guidance on evidence](#).

Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)

1a. High Impact: H M L I

(The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.)

De.4 Subject/Topic Areas (Check all the areas that apply):

De.5 Cross Cutting Areas (Check all the areas that apply): [Disparities, Safety](#)

1a.1 Demonstrated High Impact Aspect of Healthcare: [Affects large numbers, Frequently performed procedure, Patient/societal consequences of poor quality](#)

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact (Provide epidemiologic or resource use data):

[Other proposed measures address the importance of using trained interpreters and qualified bilingual providers when communicating with patients with limited English proficiency. The proposed measure, L2: Patients receiving language services supported by qualified language services providers, uncovered serious gaps in language services delivery at the 10 hospitals participating in the Speaking Together project, as well as hospitals in LOIC and the Aligning Forces collaborative. L2 enables health care organizations to measure the effectiveness of their services. The proposed measure, L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers, allows health care organizations to determine whether their current language services resources are being used productively, given the language preferences of their patients. For example, a hospital may find that interpreters are spending, on average, only about one-third of their time interpreting in clinical encounters. This may reveal additional capacity that can be directed to clinical encounters.](#)

[Little research has addressed the issue of interpreter time spent interpreting. However, substantial research has addressed the importance of effective communication for patients with limited English proficiency. Conceptually, the measure is modeled after nursing measures that track nurse time spent in direct patient care. Nurse time spent in administrative duties may be worthwhile from an organizational point of view, but non-clinical tasks decrease the total time available for direct patient care -- a situation that can diminish overall quality.](#)

[We include here a summary of the evidence of the impact of language services on patients care for persons with limited English proficiency. Of particular interest is evidence about costs for interpreter services, which are generally not reimbursed by third-party payers. The costs of interpreter services create disincentives to their use. Health care organizations that measure performance using the proposed measure L2 will likely also want to track L5 to determine whether additional interpreter capacity is available to provide language services to patients who have indicated a preference to receive health care in a language other than English.](#)

[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](#)

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

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.

- 1a.4 Citations for Evidence of High Impact cited 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) Regenstein 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.

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

- (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.

1b. Opportunity for Improvement: H M L I

(There is a demonstrated performance gap - variability or overall less than optimal performance)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:

As hospitals begin to measure performance, and especially as they begin to track the extent to which patients who needed language services received them at critical points during the inpatient or outpatient visit, the question of whether there are sufficient resources to meet patient needs is bound to surface. Before hospitals can determine whether they are able to meet patient demand with current staffing, it is important to ensure current resources are being deployed to best meet patient needs.

This measure enables health care organizations to identify current language services capacity. In *Speaking Together*, hospitals found that interpreters performed many different tasks that did not involve direct patient care. These tasks could have been performed by another person who was not trained in medical interpreting and perhaps who did not have the level of language fluency that is required for medical interpreting. For example, some interpreters spent time calling patients to remind them of appointments, schedule or change appointment times, or to ask them to bring various documents to their appointments. The interpreter's language skills enabled them to communicate with the patients, but the tasks did not require the skills of a trained interpreter. In other cases, interpreters were extremely inefficient in terms of their deployment in various parts of a large health care organization and spent substantial amounts of time day walking (or other traveling) from one encounter to another. L5 will allow health care organizations to measure the extent to which medical interpreters are being used to deliver critical language services to patients.

NOTE: Higher scores on L5 indicate better performance. Nevertheless, the goal of L5 is not 100 percent. We asked participating hospitals to set goals for this measure, consistent with the structure and delivery of language services in their organization, the need for interpreters to take breaks, complete logs and other documentation, etc. Most of the hospitals set goals for L5 in the 65 percent range.

1b.2 Summary of Data Demonstrating Performance Gap (Variation or overall less than optimal performance across providers):

[For Maintenance – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.]

Results of the *Speaking Together* collaborative revealed relatively low productivity as measured by interpreter time spent interpreting in clinical encounters. Performance was highly variable across the 10 hospitals. In the first quarter of 2007 (when all hospitals were reporting on this measure), performance ranged from a high of 73 percent to a low of 10 percent – a 63 percentage point gap. By the end of the project, the gap was reduced to 46 percentage points and seven of the hospitals showed improvement of at least five percentage points. Despite these improvements, overall performance on this measure remained low and was similar to L2.

NOTE: Higher scores on L5 indicate better performance. Nevertheless, the goal of L5 is not 100 percent. We asked participating hospitals to set goals for this measure, consistent with the structure and delivery of language services in their organization, the need for interpreters to take breaks, complete logs and other documentation, etc. Most of the hospitals set goals for L5 in the 65 percent range.

1b.3 Citations for Data on Performance Gap: [For Maintenance – Description of the data or sample for measure results reported]

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included]
 Data on the performance gap for this measure can be found in a forthcoming paper in the Journal for Health Care Quality: "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. Anticipated publication date -- March 2012.

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance* – Descriptive statistics for performance results for this measure by population group]

This is a process measure to determine whether the time interpreters spend in medical interpretation in clinical encounters is adequate. The data on disparities by population group refers to the population of patients who need language services and who ultimately benefit when interpreters are available for their care. In addition to the information provided above, a large body of evidence supports the fact that immigrant, non-English speaking populations experience substantial disparities in health care health care (1-2).

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance* – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included]

- (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. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
 Is the measure focus a health outcome? Yes No If not a health outcome, rate the body of evidence.

Quantity: H M L I Quality: H M L I Consistency: H M L I

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	Yes <input type="checkbox"/>
L	M-H	M	Yes <input type="checkbox"/> IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No <input type="checkbox"/>
M-H	L	M-H	Yes <input type="checkbox"/> IF potential benefits to patients clearly outweigh potential harms: otherwise No <input type="checkbox"/>
L-M-H	L-M-H	L	No <input type="checkbox"/>

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service	Does the measure pass subcriterion1c? Yes <input type="checkbox"/> IF rationale supports relationship
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1c.1 Structure-Process-Outcome Relationship (*Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome*):

The proposed measure is a process measuer that tracks the percent of an interpreter’s that is spent in clinical encounters. Interpreter resources are often scarce in health care organizations and are commonly not covered by third party private or public insurance plans or programs. (Some Medicaid programs include interpreter services as a covered benefit but in practice this constitutes an extremely small percentage of total interpreter use in the U.S., and most of the states with the largest Medicaid populations with limited English proficiency are not among the ones including an interpreter benefit.) The measure links directly to effective patient care -- if interpreters are a scarce resource that is not used specifically for clinical encounters, then fewer patients will benefit from their services. This has direct consequences for quality of care and patient and provider satisfaction.

1c.2-3 Type of Evidence (*Check all that apply*):

Selected individual studies (rather than entire body of evidence), Systematic review of body of evidence (other than within guideline development)

1c.4 Directness of Evidence to the Specified Measure (*State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population*):

The evidence to support the measure relates to the need for trained medical interpreters in clinical encounters.

Two systematic literature reviews and dozens of studies support the use of language services for persons with limited English proficiency (see Jacobs E, Chen A, Karliner L, 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; Flores G. The impact of medical interpreter services on the quality of health care: a systematic review. *Med Care Res Rev.* 2005 Jun;62(3):255-99.) These and other studies identified above address the experiences of patients with LEP when interacting with the health care system and the extent to which interpreters and bilingual providers improve the safety, efficiency and overall quality of care as well as patient and provider satisfaction with care. The patient populations can vary, with some studies addressing Spanish-speaking patients only or other populations speaking various languages; also, some studies focus on care for children only; care in emergency departments; or care for patients with particular clinical conditions. The language services literature in general describes a highly vulnerable group of patients who experience substantial barriers accessing necessary care, understanding the care they receive and how to navigate the many aspects of the health care system, and how they can effectively participate in their own care and care management. The studies generally measure care across groups, with the receipt of some type of language services as the variable of interest. Some studies investigate only the delivery of any language service (e.g., any interpreter versus no interpreter), use of bilingual provider versus English-speaking only provider, or some combination of different modes of interpretation (in-person, telephone, video,) on various types of clinical services and health care processes.

1c.5 Quantity of Studies in the Body of Evidence (*Total number of studies, not articles*): The Flores review included 36 studies and the systematic review by Jacobs included over 150 studies, including many identified in the Flores review. Another systematic review (Bauer A, Alegria M. The Impact of Patient Language Proficiency and Interpreter Service Use on the Quality of Psychiatric Care: A Systematic Review. *Psychiatr Serv.* 2010 August;61(8):765-773) identified 26 studies meeting specific inclusion criteria.

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*): The body of evidence is strong in terms of the number of studies meeting qualifying criteria, but the general designs of the studies have some flaws. Studies generally do not use common definitions of language services. In some studies, language services can be provided by trained interpreters only and in others, by trained and ad hoc interpreters. The most significant flaw (in my opinion) is the lack of consistency when it comes to the "dosage" of interpretation. It is not clear that there is a common standard in terms of what it actually means to "get" an interpreter. Patients with LEP frequently have some type of interpreter service at some points in their experience with the health system, but various studies often do not even define what "getting an interpreter" actually means. The proposed measure will advance the field significantly by putting a common definition on the delivery of a language service and measuring the process of interpreter services at two clinically important points in time.

1c.7 Consistency of Results across Studies (*Summarize the consistency of the magnitude and direction of the effect*): Because of the variability in the design of the studies, and the fact that the field has not used common definitions for the delivery of language services, it is difficult to summarize the consistency of the magnitude and direction of the effect. In general, interpreter services improve safety, quality of the encounter, result in fewer errors, improve use of prevention and primary care services, conserve resources by avoiding repeated tests, and improve patient satisfaction.

1c.8 Net Benefit (*Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms*):

The net benefit of effective language services is positive -- the evidence is extremely persuasive on this point. However, no common definitions are used and therefore it is difficult to determine what patients are getting when the studies report language services versus no language services. The proposed measure will provide a common metric for the field and will link the delivery of language services directly to the patient.

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? No

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any

disclosures regarding bias: [N/A](#)

1c.11 System Used for Grading the Body of Evidence: [Other](#)

1c.12 If other, identify and describe the grading scale with definitions: [Systematic literature reviews. Evidence was not graded.](#)

1c.13 Grade Assigned to the Body of Evidence: [N/A](#)

1c.14 Summary of Controversy/Contradictory Evidence: [N/A](#)

1c.15 Citations for Evidence other than Guidelines(*Guidelines addressed below*):
[N/A](#)

1c.16 Quote verbatim, the specific guideline recommendation (Including guideline # and/or page #):

[JOINT COMMISSION STANDARDS FOR PATIENT-CENTERED COMMUNICATION](#)

[HR.01.02.01 The hospital defines staff qualifications.](#)

[EP 1 The hospital defines staff qualifications specific to their job responsibilities.](#)

[Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964.](#)

[PC.02.01.21 The hospital effectively communicates with patients when providing care, treatment, and services.](#)

[Rationae for PC.02.01.21](#)

[This standard emphasizes the importance of effective communication between patients and their providers of care, treatment and services. Effective patient-provider communication is necessary for patient safety. Research shows that patients with communication problems are at an increased risk of experiencing preventable adverse events, and that patients with limited English proficiency are more likely to experience adverse events than English speaking patients.](#)

[EP 2 The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.](#)

[NATIONAL QUALITY FORUM COMPREHENSIVE FRAMEWORK AND PREFERRED PRACTICES FOR MEASURING AND REPORTING CULTURAL COMPETENCY: A CONSENSUS REPORT](#)

[Domain 2: Integration into Management Systems and Operations](#)

[Preferred Practice 9: Implement language access planning in any area where care is delivered.](#)

[Domain 3: Patient-Provider Communication](#)

[Preferred Practice 12: Offer and provide language access resources in the patient's primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge.](#)

[Preferred Practice 13: Determine and document the linguistic needs of a patient or legal guardian at first points of contact, and periodically assess them throughout the healthcare experience.](#)

[Preferred Practice 14: Maintain sufficient resources for communicating with patients in their primary written and spoken languages through qualified/competent interpreter resources, such as competent bilingual or multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting services, credentialed volunteers, and others, to ensure timely and high-quality communication.](#)

[Preferred Practice 17: Ensure that a qualified interpreter reads a document to a patient if the patient cannot read the translated document.](#)

[Preferred Practice 19: Communicate key information about the proposed treatments or procedures for which patients are being asked to provide informed consent.](#)

[Domain 4: Care Delivery and Supporting Mechanisms](#)

1c.17 Clinical Practice Guideline Citation: [The Joint Commission. Advancing Effective Communication, Cultural Competences, and Patient- and Family-Centered Care: A Roadmap for Hospitals. Oakbrook Terrace, IL: The Joint Commission, 2010.](#)

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

1c.18 National Guideline Clearinghouse or other URL:

<http://www.jointcommission.org/assets/1/6/roadmapforhospitalsfinalversion727.pdf>

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? No

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:

1c.21 System Used for Grading the Strength of Guideline Recommendation: Other

1c.22 If other, identify and describe the grading scale with definitions: N/A

1c.23 Grade Assigned to the Recommendation: N/A

1c.24 Rationale for Using this Guideline Over Others: N/A

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?

1c.25 Quantity: High 1c.26 Quality: Moderate 1c.27 Consistency: Moderate

Was the threshold criterion, *Importance to Measure and Report*, met?

(1a & 1b must be rated moderate or high and 1c yes) Yes No

Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.

For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & 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. (evaluation criteria)

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See [guidance on measure testing](#).

S.1 Measure Web Page (In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained). Do you have a web page where current detailed specifications for this measure can be obtained? Yes

S.2 If yes, provide web page URL:

http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3870218A-5056-9D20-3D6DA9069C41BB77.pdf

2a. RELIABILITY. Precise Specifications and Reliability Testing: H M L I

2a1. Precise Measure Specifications. (The measure specifications precise and unambiguous.)

2a1.1 Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome):

The total number of minutes interpreters spent providing interpretation during clinical encounters during the calendar month, stratified by language.

2a1.2 Numerator Time Window (The time period in which the target process, condition, event, or outcome is eligible for inclusion):

Time window is a single point in time. All cases in the denominator are equally eligible to appear in the numerator.

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

2a1.3 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, codes with descriptors, and/or specific data collection items/responses):

Inclusions:

- Time worked for clinical encounters (e.g., clinical assessment; discharge instructions, care plan management, informed consent discussions, discharge planning, etc.).
- Time worked for clinical encounters for hospital operated on-site interpreters.
- Time worked for hospital operated telephone interpreters and hospital operated video interpreters.

Exclusions:

- Non-clinical interpreter encounters (e.g., billing issues, need to interpret patient meal preferences, appointment reminders, parking instructions, etc.).
- Encounters with bilingual providers and/or other bilingual hospital workers/employees.
- Outside vendor telephone interpreter and/or outside vendor video interpreters.
- Agency and contract interpreters.

Data Elements:

Interpreter encounters
Clinical encounters
Encounter start time
Encounter end time

2a1.4 Denominator Statement (Brief, narrative description of the target population being measured):

The total number of minutes worked by interpreters during the calendar month, stratified by language.

2a1.5 Target Population Category (Check all the populations for which the measure is specified and tested if any): Adult/Elderly Care, Children's Health, Maternal Care, Populations at Risk

2a1.6 Denominator Time Window (The time period in which cases are eligible for inclusion):

Time window is a single point in time. All cases in the denominator are equally eligible to appear in the numerator

2a1.7 Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):

Data Elements:

Minutes worked
Preferred spoken language for health care

2a1.8 Denominator Exclusions (Brief narrative description of exclusions from the target population):

Exclusions:

- Vacation, sick time, orientation and education leave.
- Agency and contract interpreters.
- Persons whose primary responsibility is administrative (e.g., interpreter manager, supervisor, director, interpreter department dispatcher, secretary, and scheduler).
- Interpreters assigned to non interpreter duties (e.g., shift supervisor, special projects).
- Outside vendor telephone interpreters and outside vendor video interpreters.
- Bilingual providers and other bilingual hospital workers/employees.

2a1.9 Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):

Data Collection Approach:

Retrospective from payroll or staffing records and encounter logs.

Data Accuracy/Data Completeness: Payroll or staffing records should be audited to remove vacation, sick time, orientation,

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

education leave, and committee time, etc.; as well as to ensure that ineligible staff are not included (e.g., interpreter manager, supervisor, director, interpreter department dispatcher, secretary, scheduler, etc). Variation may exist in data recording practices; therefore, data recording practices may require evaluation, monitoring and training to ensure consistency.

Measure Analysis Suggestions: Hospital may want to design reporting systems to examine rates by individual interpreter, by location.

2a1.10 Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses):

Measure can be stratified by language of interpretation. If interpreter provides services in one non-English language, all time spent interpreting in clinical situations can assumed to be for that language and recorded as such. Some interpreters provide services for more than one non-English language. Language of encounter should be recorded for each encounter.

2a1.11 Risk Adjustment Type (Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13): No risk adjustment or risk stratification **2a1.12 If "Other," please describe:**

2a1.13 Statistical Risk Model and Variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.):

N/A

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. Type of Score: Rate/proportion

2a1.19 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

2a1.20 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. The measure calculates the percent of time interpreters spend in clinical encounters. Inclusion and exclusion criteria are identified above. Interpreters log start and finish times for clinical encounters and rates are calculated as a percent of work time.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:

URL

http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3870218A-5056-9D20-3D6DA9069C41BB77.pdf

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):

Measure includes all interpreter encounters -- it is not based on a sample or survey.

2a1.25 Data Source (Check all the sources for which the measure is specified and tested). If other, please describe:

Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records

2a1.26 Data Source/Data Collection Instrument (Identify the specific data source/data collection instrument, e.g. name of

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

database, clinical registry, collection instrument, etc.): [Data Collection Approach: Retrospective from payroll or staffing records and encounter logs.](#)

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment: [URL](#)

http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3870218A-5056-9D20-3D6DA9069C41BB77.pdf

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:

[URL](#)

http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3870218A-5056-9D20-3D6DA9069C41BB77.pdf

2a1.33 Level of Analysis (Check the levels of analysis for which the measure is specified and tested): [Clinician : Group/Practice, Facility](#)

2a1.34-35 Care Setting (Check all the settings for which the measure is specified and tested): [Ambulatory Care : Clinic/Urgent Care, Hospital/Acute Care Facility](#)

2a2. Reliability Testing. (Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability.)

2a2.1 Data/Sample (Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

The measure was pilot tested in one inpatient and in one outpatient care setting in two (2) large metropolitan hospitals in October 2006.

The measure was used by the 10 grantee hospitals in the Speaking Together National Language Services Collaborative from November 2006 - May 2008. Ten hospitals reported data monthly on 40,000 - 60,000 patients seen in inpatient and ambulatory care settings. Hospitals ranged in size from 11,500 - 44,000 admissions, included 2 children's hospitals and were comprised of both academic teaching and non-teaching community hospitals.

The measures specifications were revised based on the learning from the Speaking Together Collaborative and input from the participating hospitals.

- Hospital A - New York NY; Public hospital; Beds 771; Annual Admissions 26,068; Annual interpreter encounters 58,962; Percent of interpreter encounters in top 5 languages-60% Spanish;26% Mandarin; 6% Cantonese; 3% Polish; 2% French

- Hospital B - Cambridge MA; Public hospital; Beds 350; Annual Admissions 15,263; Annual interpreter encounters 140,556; Percent of interpreter encounters in top 5 languages-55% Brazilian Portuguese; 24% Spanish; 7% Haitian Creole; 2% Euro Portuguese; 2% Hindi

- Hospital C - Minneapolis MN; Public hospital; Beds 434; Annual Admissions 22,117; Annual interpreter encounters 120,000; Percent of interpreter encounters in top 5 languages-60% Spanish; 12% Somali; 4% Russian; 3% Hmong; 3% Hmong; 1% Laotian

- Hospital D - Phoenix AZ; Non-profit hospital; Beds 285; Annual Admissions 11,712; Annual interpreter encounters 48,043; Percent of interpreter encounters in top 5 languages->99% Spanish

- Hospital E - St. Paul, MN; Non-profit hospital; Beds 399; Annual Admissions 22,827; Annual interpreter encounters 28,887; Percent of interpreter encounters in top 5 languages- 50% Spanish; 12% Hmong; 10% Somali; 9% Vietnamese; 4% ASL

- Hospital F - Rochester, NY; Non-profit hospital; Beds 973; Annual Admissions 36,321; Annual interpreter encounters 14,885; Percent of interpreter encounters in top 5 languages-46% Spanish; 35% ASL; 3% Vietnamese; 2% Russian; 2% Arabic

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

- Hospital G – Seattle, WA; Non-profit hospital; Beds 250; Annual Admissions 11,608; Annual interpreter encounters 40,690; Percent of interpreter encounters in top 5 languages-55% Spanish; 7% Vietnamese; 4% Somali; 4% Russian; 2% Cantonese
- Hospital H – Sacramento, CA; Public hospital; Beds 526; Annual Admissions 27,946; Annual interpreter encounters 65,000; Percent of interpreter encounters in top 5 languages-58% Spanish;20%Russian; 8% Mien; 5% Hmong; 5% Cantonese
- Hospital I – Worcester, MA; Non-profit hospital; Beds 731; Annual Admissions 44,231; Annual interpreter encounters 59,134; Percent of interpreter encounters in top 5 languages-62% Spanish; 13% Portuguese; 7% Vietnamese; 5% Albanian; 3% ASL
- Hospital J – Ann Arbor, MI; Non-profit hospital; Beds 802; Annual Admissions 42,811; Annual interpreter encounters 21,503; Percent of interpreter encounters in top 5 languages-22% Spanish; 18% Chinese; 14% Japanese; 12% Arabic; 10% Russian

More than 50,000 LEP patients were included in the Speaking Together collaborative. The proposed measure was subsequently used in another learning collaborative with nine hospitals. Through the development phases, pilot testing, testing in the Speaking Together collaborative and the subsequent round with 9 additional hospitals, the measure proved to be extremely reliable.

2a2.2 Analytic Method (*Describe method of reliability testing & rationale*):

Development of Interpreter Services Performance Measures

In 2006, the Robert Wood Johnson Foundation funded Speaking Together: National Language Services Network, an 18-month national program aimed at improving the delivery of language services through the use of quality improvement techniques. Ten hospitals were selected through an open, competitive solicitation to participate in the program. The 10 hospitals were: Bellevue Hospital Center (New York, NY); Cambridge Health Alliance (Cambridge, MA); Hennepin County Medical Center (Minneapolis, MN); Phoenix Children's Hospital (Phoenix, AZ); Regions Hospital (St. Paul, MN); The University of Rochester—Strong Memorial Hospital (Rochester, NY); Seattle Children's Hospital and Medical Center, (WA); the University of California Davis Medical Center (Sacramento, CA); the University of Massachusetts Memorial Medical Center (Worcester, MA); and, University of Michigan Health System (Ann Arbor, MI).

Because the field of language services did not have commonly used language performance measures, the Speaking Together National Program Office (NPO) at the George Washington University developed a set of performance measures for language services for use throughout the learning collaborative. As a starting point for measures development for the field, the Speaking Together NPO made an explicit decision to initially focus on signed and spoken interpreter services measures with a plan to develop measures for written (translation) services at a later date. The Speaking Together NPO employed a multi-stage process to identify and develop a set of measures for signed and spoken interpreter services:

Stage 1: Identifying a framework for quality: The Speaking Together NPO used the Institute of Medicine's (IOM's) six dimensions of quality, as articulated in *Crossing the quality chasm: A new health system for the 21st century*, as a framework for developing language service performance measures. These dimensions (safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness) are outlined in Figure 1.

Figure 1: IOM Domains of Quality, Adapted for Language Services

Domain Principle

Safe: Avoiding injuries to patients from the language assistance that is intended to help them.

Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

Effective: Providing language services based on scientific knowledge that contribute to all who could benefit, and refraining from providing services to those not likely to benefit.

Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Equitable: Providing language assistance that does not vary in quality because of personal characteristics such as language preference, gender, ethnicity, geographic location, and socioeconomic status.

Patient-Centered: Providing language assistance that is respectful of and responsive to individual patient preferences, needs, culture and values, and ensuring that patient values guide all clinical decisions.

Stage 2: Reviewing the relevant literature: The Speaking Together NPO conducted extensive literature searches to support the

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

development of evidence-based measures and identify key quality concerns related to the delivery of language services in hospitals and other health care settings.

Stage 3: Interviewing experts: The Speaking Together NPO interviewed experts in the field of language services and directors of established hospital-based interpreter services programs to help identify issues related to quality of language services and potentially valuable performance measures. For a full listing of the contributors, please see Additional.

Stage 4: Identifying a framework for organizational change: The Speaking Together NPO used Nerenz and Neil's Performance Measures for Health Care Systems (2001) as a guidepost to look across an organization and identify how care is organized and delivered. Using this framework, we identified components of language and interpreter services that address significant and important quality issues pertinent to the delivery of language services and identified measurable events as potentially valuable performance measures.

Stage 5: Developing the measures: Using the frameworks mentioned above, as well as information from the literature and interviews, the Speaking Together NPO developed a set of 10 draft process measures for review and field testing.

Stage 6: Getting feedback on the draft measures: The Speaking Together NPO assembled a panel of experts in language services, who have contributed greatly to the literature in the field, to review the 10 draft performance measures and evaluate them according to uniform evaluation criteria.

Stage 7: Meeting with clinicians and interpreters services directors: The draft measures were reviewed by an expert panel consisting of medical directors, physician leaders and interpreter services directors who convened in Washington, DC, in September 2006 to review the 10 draft measures and evaluate each according to its importance to quality, feasibility in terms of data collection, clarity and accuracy of description. (For a full listing of the contributors, please see Additional.) The expert panel recommended the following 5 of the 10 measures for implementation in acute care hospitals and outpatient settings:

- The percent of patients who have been screened for their preferred spoken language.
- The percent of LEP patients receiving initial assessment and discharge instructions from assessed and trained interpreters or from bilingual providers assessed for language proficiency.
- The percent of encounters where the patient wait time for interpreter is 15 minutes or less.
- The percent of time interpreters spend providing medical interpretation in clinical encounters with patients.
- The percent of encounters interpreters wait less than 10 minutes to provide interpreter services to provider and patient.

Stage 8: Field testing the measures: Two hospitals with established language services programs participated in a week-long pilot test of the recommended performance measures, gathering information on the feasibility of data collection, usefulness of data reporting formats, and barriers and challenges associated with successful data collection and submission. (Please note: The two pilot sites were not part of the 10 Speaking Together grantee hospitals.)

Stage 9: Implementing the measures: The 10 Speaking Together grantee hospitals used the measures throughout the 18-month learning collaborative, applying quality improvement methodologies to improve the delivery of interpreter services. The Speaking Together hospitals reported data (stratified by language) on the measures to the NPO monthly for the duration of the 18-month program. Hospitals also provided information about data collection challenges, feedback on the data abstraction instructions, data variables and definitions in monthly reports, at on-site visits with the NPO, during monthly conference calls, and at the 4 collaborative meetings.

Stage 10: Revising and refining data collection specifications: The NPO revised the measures based on the learnings from the Speaking Together collaborative then convened a panel of language services experts to review the measures revisions for clarity and accuracy of descriptions, definitions and abstraction instructions. The panel was comprised of medical directors and quality improvement specialists from 5 Speaking Together hospitals. (For a full listing of the contributors, please see Additional.) Revisions to the 5 measures were largely centered on clarifying numerator and denominator descriptions, clarifying inclusions and exclusions descriptions and defining data elements. The work in this stage has allowed us to standardize the measures and to create standardized technical specifications.

Aligning Forces for Quality: Language Quality Improvement Collaborative

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

From July 2009-October 2010, the measures were used in the Aligning Forces for Quality Language Quality Improvement Collaborative (LQIC). As in Speaking Together, the LQIC hospitals reported monthly data, stratified by language, on the measures to the NPO. Hospitals also provided information about data collection challenges, feedback on the data abstraction instructions, data variables and definitions in monthly reports, at on-site visits with the NPO, during monthly conference calls, and at 2 collaborative meetings. The 9 LQIC hospitals were: Beaumont Hospitals (Royal Oak, MI); Central Maine Medical Center (Lewiston, ME); Cincinnati Children's Hospital (Cincinnati, OH); Harborview Medical Center (Seattle, WA); Mercy Hospital—State Street Campus (Portland, ME); Oakwood Hospital & Medical Center (Dearborn, MI); St. Joseph Hospital (Eureka, CA); St. Joseph Mercy Oakland—Trinity Health (Pontiac, MI); and, Valley Medical Center (Renton, WA).

References:

Graham, C., Ivey, S.L., Neuhauser, L. From Hospital to home: Assessing the transitional care needs of vulnerable seniors. *The Gerontologist*. Feb 2009; 49(1): 23-33

Institute of Medicine. *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press. 2001: 51-53.

Nerenz, D. and N. Neil. *Performance Measures for Health Care Systems*. Commissioned paper for the Center for Health Management Research, 2001.

Regenstein, M., Huang, J., West, C., Mead, H., Trott, J., Stegun, M. Hospital language services: Quality improvement and performance measures. *Advances in Patient Safety: New Directions and Alternative Approaches*. Agency for Healthcare Research and Quality. Rockville, MD. July 2008; Vol. 1-4: AHRQ Publication Nos. 08-0034 (1-4).

2a2.3 Testing Results (*Reliability statistics, assessment of adequacy in the context of norms for the test conducted*):

Hospitals tracked the percent of time interpreters spent in medical interpreting to gather more information about whether capacity exists within current staffing to stretch interpreter activities to meet patient need. Discussions with hospitals in Speaking Together and many others across the country revealed that interpreters often take on responsibilities in addition to medical interpretation. Some interpreters serve as patient navigators; others contact patients to remind them of appointments or assist with financial counseling and other non-medical interpreting encounters. Discussions also revealed that interpreters often spend significant portions of their day walking to and from patient encounters; filling out necessary paperwork; or helping with scheduling or other language services duties. Still others have unfilled "downtime" between encounters.

Performance on this measure was highly variable. In the first quarter of 2007 (when all hospitals were reporting on this measure), performance ranged from a high of 73 percent to a low of 10 percent – a 63 percentage point gap. By the end of the project, the gap was reduced to 46 percentage points and seven of the hospitals showed improvement of at least five percentage points. Despite these improvements, overall performance on this measure remained low and was similar to L2.

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H M L I

2b1.1 Describe how the measure specifications (*measure focus, target population, and exclusions*) **are consistent with the evidence cited in support of the measure focus** (*criterion 1c*) **and identify any differences from the evidence:**

The proposed measure has been tested across different types of hospitals, with different language services staffing arrangements and different practices in terms of the mode of interpretation used (in-person, remote simultaneous interpretation, hospital-based telephone and video services). The measure focuses on medical interpreters and the extent to which they spend their time in clinical encounters. The numerator identifies the total number of minutes interpreters spend providing interpretation during clinical encounters, stratified by language. It excludes non-clinical interpreter encounters and other types of contract or agency activities. The measure was extremely useful for language services departments and identified the activities that interpreters and others in the hospitals considered relevant to clinical care.

The measure has high face validity. Hospital staff who have reported on the measure view it as measuring precisely what it intends to measure -- that is, the percent of time that an interpreter spends in clinical care. The measure can potentially uncover information that could be unpleasant for the interpreter or the language services department to hear, for example, if they learn that trained interpreters are not spending the majority of their time in clinical encounters, while patients that need interpreter services do not receive them. The proposed measure has been accepted as part of the AHRQ National Measures Clearinghouse and has been used in two rounds of quality improvement work in inpatient and outpatient settings. The proposed measure has strong construct

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

validity and is consistent with data collection processes related to the delivery of language services.

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.*)

2b2.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

Participants in the Speaking Together collaborative were interviewed throughout the learning network about their progress with the performance measures, including the proposed measure. All participants viewed the proposed measure as accurately reflecting the effectiveness of language services delivery. Ten hospitals participated in Speaking Together and reported performance for more than 50,000 patients with limited English proficiency. At the beginning of the collaborative, the ten hospitals reported that they had approximately 250 FTE staff devoted to interpreter services. This provided a large group of individuals to test the measure's validity, usefulness and reliability.

2b2.2 Analytic Method (*Describe method of validity testing and rationale; if face validity, describe systematic assessment*):

As indicated above, the proposed measure has strong face validity. The measure was developed after a thorough review of the literature, structured interviews with providers of language services in hospitals and health systems (generally directors of interpreter services) as well as the clinical staff who worked with interpreters (generally directors of ambulatory services or other service lines). We also talked to several interpreters to learn about the many tasks that fall within their routine responsibilities as a staff interpreter. We convened an expert panel of interpreter services and ambulatory service directors using a Delphi panel to systematically review the proposed measure on specific review criteria. We pilot tested the measure, as approved by the expert panel, in one large acute care hospital with substantial numbers of staff interpreters and high demand for language services and a children's hospital with similar characteristics. No substantial changes to the proposed measure were required following the pilot test. We used the proposed measure throughout the Speaking Together learning network. Following the Speaking Together learning network, we convened representatives from our initial expert panel as well as some Speaking Together participants to review the validity, usefulness, and adequacy of the proposed measure. The group strongly supported the use of the proposed measure with no substantive modifications.

2b2.3 Testing Results (*Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment*):

We did not conduct statistical tests of the adequacy of the measure.

POTENTIAL THREATS TO VALIDITY. (*All potential threats to validity were appropriately tested with adequate results.*)

2b3. Measure Exclusions. (*Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.*)

2b3.1 Data/Sample for analysis of exclusions (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

For the numerator, we excluded non-clinical interpreter encounters, encounters with bilingual providers and/or other bilingual hospital workers/employees, outside vendor telephone interpreters and/or outside vendor video interpreters, and agency and contract interpreters.

For the denominator, we excluded vacation, sick time, orientation and education leave; agency and contract interpreters; persons whose primary responsibility is administrative; interpreters assigned to non-interpreter duties; outside vendor telephone and video interpreters; and bilingual providers and other bilingual hospital workers/employees. We did not conduct additional analyses of exclusions.

2b3.2 Analytic Method (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference*):

No additional analysis was conducted on exclusions. The exclusions did not meet the criteria for this measure and were appropriate given the purpose of the proposed measure.

2b3.3 Results (*Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses*):

No statistical analysis was performed for an analysis of exclusions.

2b4. Risk Adjustment Strategy. (*For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.*)

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

2b4.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

No risk adjustment was performed. This is a process measure with a target identified by the specific health care organization. Most of the participating hospitals identified a goal of approximately 65 percent for this measure.

2b4.2 Analytic Method (*Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables*):

No risk adjustment was used. Performance was stratified by language, which enabled health care organizations to determine whether interpreters in various languages were spending similar or different percentages of their time in clinical encounters

2b4.3 Testing Results (*Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata*):

No risk adjustment was used

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: No need for risk-adjustment. This is a process measure that applies to all interpreters who meet the measure inclusion/exclusion criteria. The measure does not differentiate between modes of interpretation, although that could be an additional stratification category. For example, hospital-based telephone interpreters may spend different percentages of their time in clinical encounters because they do not need to travel from one location to another for an in-person encounter.

2b5. Identification of Meaningful Differences in Performance. (*The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.*)

2b5.1 Data/Sample (*Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

The measure was used from November 2006-February 2008 by 10 hospitals and health systems in seven states. Four public and six non-profit hospitals, including two children's hospitals, were included in the collaborative. The 10 hospitals differed in terms of their size, scope of language services program, and geographic location in the country. All of the participating hospitals had relatively robust language services programs as a requirement for participation. At the time of the program, the hospital with the largest language services program reported a total of 63 FTE for language services staff and over 140,000 interpreter encounters annually; the smallest language services program reported eight FTE staff for language services and approximately 40,000 interpret encounters annually. In all but one hospital, Spanish was the most common language spoken by LEP patients. Many of the hospitals had interpreters who spoke Mandarin, Portuguese, Haitian Creole, Somali, Hmong, Arabic, Russian, and Cantonese. Most also had interpreters who communicated using American Sign Language, which was included among languages requiring effective quality improvement interventions.

2b5.2 Analytic Method (*Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance*):

We tracked performance on a monthly basis across the 10 hospitals. We considered a hospital to have improved performance if it showed improvement of at least five percentage points.

2b5.3 Results (*Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance*):

Performance on L5 was highly variable. In the first quarter of 2007 (when all hospitals were reporting on this measure), performance ranged from a high of 73 percent to a low of 10 percent – a 63 percentage point gap. By the end of the project, the gap was reduced to 46 percentage points and seven of the hospitals showed improvement of at least five percentage points. Despite these improvements, overall performance on this measure remained low and was similar to L2.

2b6. Comparability of Multiple Data Sources/Methods. (*If specified for more than one data source, the various approaches result in comparable scores.*)

2b6.1 Data/Sample (*Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

All interpreters and encounters that met inclusion criteria were in the proposed measure. The Speaking Together hospitals, interpreter staffing and patient populations are described above.

2b6.2 Analytic Method (Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure):

Rates were calculated for each participating hospital by quarter/year. All hospital scores were available to all hospitals in the collaborative -- no additional testing for comparability scores was conducted.

2b6.3 Testing Results (Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted):

Performance within the collaborative was highly transparent, with hospitals able to view other hospitals' performance to allow them to learn strategies and techniques for more successful performers. No additional statistical analyses were conducted.

2c. Disparities in Care: H M L I NA (If applicable, the measure specifications allow identification of disparities.)

2c.1 If measure is stratified for disparities, provide stratified results (Scores by stratified categories/cohorts): Hospitals stratified the results of the measure by language. We did not track performance by language at the program office level.

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:

Measure is designed to be able to report/identify potential disparities.

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met? (Reliability and Validity must be rated moderate or high) Yes No

Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)

C.1 Intended Purpose/ Use (Check all the purposes and/or uses for which the measure is intended): Public Reporting, Quality Improvement (Internal to the specific organization), Regulatory and Accreditation Programs

3.1 Current Use (Check all that apply; for any that are checked, provide the specific program information in the following questions): Public Reporting, Regulatory and Accreditation Programs, Quality Improvement (Internal to the specific organization)

3a. Usefulness for Public Reporting: H M L I
(The measure is meaningful, understandable and useful for public reporting.)

3a.1. Use in Public Reporting - disclosure of performance results to the public at large (If used in a public reporting program, provide name of program(s), locations, Web page URL(s)). If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: [**For Maintenance** – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.]

The measure is not publicly reported. Endorsement from NQF could establish a common platform for public reporting as a quality measure.

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

The results of the collaborative and the proposed measure can be viewed in the follow publicly available publications:

Regenstein M, Huang J, West C, Trott J, Mead H, Andres E. Improving the quality of language services delivery: Findings from a hospital quality improvement initiative. *Journal for Healthcare Quality* 2012: Forthcoming, March 2012.

Regenstein, M. (2007). Measuring and improving the quality of hospital language services: insights from the Speaking Together collaborative. *Journal of General Internal Medicine*, 22 Suppl 2, 356-59.

Regenstein, M., Huang, J., West, C., Mead, H., Trott, J. & Stegun, M. (2008). Hospital language services: quality improvement and performance measures. *Advances in patient safety: new directions and alternative approaches*. Rockville, MD: Agency for Healthcare Research and Quality.

3a.2. Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: The measure provides information about the use of language services resources. These resources are absolutely critical to the provision of high-quality care for persons with limited English proficiency. However, most hospitals and other health care organizations do not know (and do not track in any consistent way) whether their language services resources are being deployed in a productive way to advance patient care.

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s): [The Joint Commissions Standards for Patient Provider Communication](#)

<http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>

3b. Usefulness for Quality Improvement: H M L I

(The measure is meaningful, understandable and useful for quality improvement.)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s):

[For Maintenance – If not used for QI, indicate the reasons and describe progress toward using performance results for improvement].

Organizations were able to use the measures to improve the delivery of interpreter services to LEP populations. Across 2 collaboratives/learning networks (Speaking Together and the Aligning Forces for Quality Language Quality Improvement Collaborative) organizations have used the measures and results to better identify patients needing services and identify the organizations true demand for services; measure progress towards delivery of services; and use measures to identify waste and streamline systems.

Results are documented in:

Regenstein M, Huang J, West C, Trott J, Mead H, Andres E. Improving the quality of language services delivery: Findings from a hospital quality improvement initiative. *Journal for Healthcare Quality* 2012: Forthcoming in March 2012.

Regenstein, M. (2007). Measuring and improving the quality of hospital language services: insights from the Speaking Together collaborative. *Journal of General Internal Medicine*, 22 Suppl 2, 356-59.

Regenstein, M., Huang, J., West, C., Mead, H., Trott, J. & Stegun, M. (2008). Hospital language services: quality improvement and performance measures. *Advances in patient safety: new directions and alternative approaches*. Rockville, MD: Agency for Healthcare Research and Quality.

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated (e.g., QI initiative), describe the data, method and results:

The measures have been tested extensively and feedback has been sought on several occasions from individuals who are most familiar with on-the-ground interpreter services in hospital settings. Their feedback indicates that they are meaningful, easy to understand, and extremely useful for quality improvement.

As part of the Speaking Together program, we commissioned a series of focus groups with patients at the participating hospitals.

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

On average, 3 focus groups were held with different language groups who used or would potentially use language services to facilitate their communication with the participating health care organization. Patients clearly indicated that they recognize the need for high-quality language services and that they understand that their care and safety are compromised without these services. They identified barriers to receiving these services at all of the hospitals.

Overall, to what extent was the criterion, *Usability*, met? H M L I
Provide rationale based on specific subcriteria:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)

4a. Data Generated as a Byproduct of Care Processes: H M L I

4a.1-2 How are the data elements needed to compute measure scores generated? (*Check all that apply*).

Data used in the measure are:

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

Retrospective from payroll or staffing records and encounter logs

4b. Electronic Sources: H M L I

4b.1 Are the data elements needed for the measure as specified available electronically (*Elements that are needed to compute measure scores are in defined, computer-readable fields*): Some data elements are in electronic sources

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources: This is new data collection and not required by other programs. Organizations keep these data in a variety of places. This requires that an interpreter record the time the encounter begins and the time it ends. These could be built into electronic systems.

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H M L I

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:

The measure is straightforward and instructions were provided in group settings and one-on-one on the rationale for the measures, specific variables, definitions and calculation of the measure. A detailed specifications manual was created.

4d. Data Collection Strategy/Implementation: H M L I

A.2 Please check if either of the following apply (*regarding proprietary measures*):

4d.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 (*e.g., fees for use of proprietary measures*):

These are new data collection and not required for any other programs.

Organizations needed to establish system to record start and end time for interpreting encounter to compute the measure. Paper tracking was most often used for this measure with the use of various records and tracking forms to generate the measure. The data for on-site interpreters, over the phone/video and contract / agency interpreters was often kept in different reports. Once systems are in place the data collection and reporting take minimal time.

Overall, to what extent was the criterion, *Feasibility*, met? H M L I
Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes No

Rationale:

NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

If the Committee votes No, STOP.

If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND 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 before a final recommendation is made.

5.1 If there are related measures (*either same measure focus or target population*) or competing measures (*both the same measure focus and same target population*), list the NQF # and title of all related and/or competing measures:

5a. Harmonization

5a.1 If this measure has 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 Measure(s)

5b.1 If this measure has 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

CONTACT INFORMATION

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Co.6 Additional organizations that sponsored/participated in measure development:

[Stage 8: Interpreter Measures](#)

[Measure Field Test Hospitals](#)

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ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development

Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

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NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

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NQF #1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

Regions Hospital St. Paul, MN
Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward:
Measure Developer/Steward Updates and Ongoing Maintenance Ad.3 Year the measure was first released: 2006 Ad.4 Month and Year of most recent revision: 08, 2009 Ad.5 What is your frequency for review/update of this measure? Annual Ad.6 When is the next scheduled review/update for this measure? 06, 2012
Ad.7 Copyright statement: © 2009 Department of Health Policy, George Washington University School of Public Health and Health Services.
Ad.8 Disclaimers:
Ad.9 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.
Date of Submission (MM/DD/YY): 01/17/2012