Aligning Forces for Quality

Improving Language Services Performance Measures

Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

Using the *Language Services Performance Measures*

This portion of the Language Services Performance Measures guide provides a brief overview of the information contained within each section of the manual. It is intended for use as a quick reference to assist in the implementation of the Language Services performance measures. The sections of the manual are interrelated and have been designed to be used together.

Section I –Introduction and Background
This section provides background information about the performance measures development framework. It describes principles underlying the framework development and provides more information about how the measures were revised after the *Speaking Together: National Language Services Network* collaborative and the development of translation measure.

Section II – Measure Information Forms and Data Abstraction Guidelines
This section provides a Measure Information Form (MIF) and Data Abstraction Guideline for each measure in the set. The MIF contains detailed information about the measure, such as the measure description and type of measure (e.g., process or outcome), inclusions and exclusions, and the required data elements. The data abstraction guideline for each measure provides guidance in directing the data collection process.

Section III – Data Elements Listing
The Data Elements Listing specifies which data elements must be collected for each measure in the set. It provides a listing of the required data elements by both data element and measure.

Section IV – Data Collection
The section provides manual data collection tools, including templates, instructions, and examples of each data collection tool.

Section V – Glossary
This section provides definitions for terms used in the measure set.

Section VI – References
This section provides the selected literature for each of the measures. The literature provides information about the measure's importance to clinical care and the delivery of language services.

Language Services Performance Measures

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Introduction and Background

Language Services Performance Measures Set

This Language Services Performance Measures guide was developed from the learning of the *Speaking Together: National Language Services Network* collaborative and from recommendations through the measures development, review and revisions processes. The development and standardization of this initial set of Language Services Performance Measures is an important step in allowing organizations to measurably assess the language needs and provision of language services to limited English-proficient (LEP) patients.

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 (10) 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 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 Appendix B.

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 Appendix B.) 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 Appendix B.) 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.

Development of Performance Measures for Translation Services

As a starting point for measures development for the language services field, *Speaking Together* made an explicit decision to focus on signed or spoken interpreter services, excluding written (translation) services. Once the interpreter measures were revised we turned our attention to translation (written) services. The field of language services currently does not have standardized performance measures for translation. In order to develop translation services performance measures, the NPO decided to follow

steps similar to what we used to develop measures for *Speaking Together,* providing a robust, sound process for development of the measures.

The *Speaking Together* NPO conducted extensive literature searches to support the development of evidence-based performance measures for translation services and to identify key quality concerns related to the delivery of translation services in hospitals and other health care settings. We interviewed numerous experts in the field of language services and translation as well as directors of established hospital-based interpreter services programs to help identify the quality issues related to translation services; to understand the operational aspects of translation services in hospitals, outpatient settings and community health centers; and to identify potential performance measures for translation services.

We used the IOM and Nerenz frameworks identified above, as well as information from the literature and interviews, to develop a set of 4 draft translation services process measures for review. We employed a two level review process for the measures. First, the draft measures were reviewed by an expert panel comprised of persons most likely to use the measures on a day-to-day basis: medical directors, nursing leaders, interpreter services directors and translation services experts from acute hospitals, outpatient settings and community health centers. Then, the expert panel convened in Washington, DC, in January 2009 to review and evaluate each of the 4 draft translation services process measures according to its importance to quality, feasibility in terms of data collection, clarity and accuracy of description. Concurrently, we assembled a panel of nationally recognized experts in language and translation services, who have made substantial contributions to the literature, to also review the 4 draft performance measures and evaluate them according to the same uniform evaluation criteria. For a full listing of the contributors, please see Appendix B.

The experts ultimately recommended 3 of the 4 measures for implementation. However, while it was agreed that all 4 measures were important indicators of quality for LEP patients, reviewers expressed concern that the data collection feasibility for 3 of the 4 measures may be too burdensome and that more information may be needed to better understand how an organization could implement these 3 measures. The following measure was recommended for addition to the Language Services performance measure set:

- *The percent of patients who have been screened for their preferred written language for health care information*

Expert reviewers agreed that screening patients for written language needs would form the foundation for other performance measures. The *Speaking Together* NPO decided that a field test of this measure was not necessary as it is similar to the measure addressing spoken language need.

Aligning Forces for Quality: **Language Quality Improvement Collaborative**

From July 2009-October 2010, the measures (including the new translation measure) 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)l; 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).

Measure Set Listing

Language Services Performance Measures

L1A) Screening for preferred spoken language for health care.

L1B) Screening for preferred written language for health care information.

L2) Patients receiving language services supported by qualified language service providers.

L3) Patient wait time to receive interpreter services.

L4) Interpreter wait time to deliver interpreter services.

L5) Time spent interpreting.

Measure Information Form

Measure Set: Language Services

Performance Measure ID: L1A

Performance Measure Name: Screening for preferred spoken language for health care.

Description: The percent of patient visits and/or admissions where preferred spoken language for health care is screened and recorded.

Domain of Quality: *Effectiveness, Equity, Patient-centeredness*

Rationale: Hospitals cannot provide adequate and appropriate language services to their patients if they do not create mechanisms to screen patients for limited English-proficiency (LEP) 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 spoken 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 spoken care in and the extent to which this information is recorded.

Type of Measure: Process. The process and questions used to screen and record preferred spoken language for health care, including English and American Sign Language (ASL).

Improvement Noted As: An increase in the percent of patients whose preferred spoken language for health care is screened and recorded.

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, stratified by language, including English, declined, or unavailable.

Inclusions:

- Admissions and/or visits where the patient's preferred spoken language for health care is recorded.
- Admissions and/or visits where the patient declined to answer the screening question.

Exclusions:

- Admissions and/or visits where the patient's spoken language preference for health care is not recorded.

Data Elements:
Preferred spoken language for health care
Admissions
Visits

Denominator Statement: The total number of hospital admissions, visits to the emergency department, and outpatient visits, stratified by language, including English, declined, or unavailable.

Inclusions:

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

Exclusions:

- Lab specimens and other types of registrations that have a medical record number but are not attached to patients that physically came to the hospital.

Data Elements:
Admissions
Visits

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required elements include administrative data and medical record documents.

Data Accuracy/Data Completeness: Variation may exist in data recording practices; therefore, data recording practices may require evaluation, monitoring and training to ensure consistency. Electronic data collection systems with drop down menus defaulting to *English* may increase the likelihood of error. Hospitals should consider screening for preferred spoken language for health care at the point where a patient initially accesses health care in the hospital, emergency department, or ambulatory unit or clinic**.**

Measure Analysis Suggestions: Hospitals may want to develop drill down information for analysis with data reported by location.

Sampling: 100% of all admissions and patient visits.

Age Groups: All.

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

Selected Literature:

Collecting race, ethnicity, and primary language data: Tools to improve quality of care and reduce health care disparities. The Health Research & Education Trust. 2005.

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

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.

Hasnain-Wynia, R., Pierce, D., Pittman, M. Who, when, and how: The current state of race, ethnicity, and primary language data collection in hospitals. The Commonwealth Fund. May 2004.

Hakimzadeh S, Cohn D. English usage among Hispanics in the United States. Pew Hispanic Center, The Henry J. Kaiser Family Foundation. 2007.

Nailon, R.E. The assessment and documentation of language and communication needs in healthcare systems: Current practices and future directions for coordinating safe, patient-centered care. *Nurs Outlook* 2007; 55: 311-317.

Pew Hispanic Center. Bilingualism (Survey brief). The Henry J. Kaiser Foundation. March 2004.

Regenstein, M, Sickler, D. Race, ethnicity, and language of patients: Hospital practices regarding collection of information to address disparities in health care. National Public Health and Hospital Institute. January 2006.

Regenstein M, Mead H, Muessig KE, Huang J. Challenges in language services: Identifying and responding to patients' needs. *J Immigrant Minority Health*. Published online only. June 2008.

Data Abstraction Guidelines

Measure: L1A: *Screening for preferred spoken language for health care.*

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 <u>not</u> 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 <u>not</u> 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.

Inclusions and Exclusions:

	Numerator	Denominator
Inclusions	• Admissions and/or visits where the patient's preferred spoken language for health care is recorded. • Admissions and/or visits where the patient declined to answer the screening question.	• Scheduled and unscheduled visits. • Elective, urgent and emergent admissions. • Short stay and observation patients. • Transfers from other facilities.
Exclusions	• Admissions and/or visits where the patient's spoken language preference for health care is not recorded.	• Lab specimens and other types of registrations that have a medical record number but are not attached to patients that physically came to the hospital.

Measure Information Form

Measure Set: Language Services

Performance Measure ID: L1B

Performance Measure Name: Screening for preferred written language for health care information.

Description: The percent of patient visits and admissions where preferred written language for health care information is screened and recorded.

Domains of Quality: *Effectiveness, Equity, Patient-centeredness*

Rationale: Hospitals cannot provide adequate language services to patients if they do not create mechanisms to screen patients for limited English-proficiency (LEP) and record patients' preferred written language for health care information. Standard practices of collecting preferred written language for health care would assist hospitals in planning for demand. Access to and availability of patient written 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 read health care materials and the extent to which this information is recorded.

Type of Measure: Process. The process and questions used to screen and record preferred written language for health care information, including English and Braille.

Improvement Noted As: An increase in the percent of patients whose preferred written language for health care information is screened and recorded.

Numerator Statement: The number of hospital admissions, visits to the emergency department, and outpatient visits where preferred written language for health care information is screened and recorded, stratified by language, including English, declined, or unavailable.

Inclusions:

- Admissions and/or visits where the patient's preferred written language for health care information is recorded.
- Admissions and/or visits where the patient declined to answer the screening question.

Exclusions:

- Admissions and/or visits where the patient's written language preference for health care information is not recorded.

Data Elements:
Preferred written language for health care information
Admissions
Visits

Denominator Statement: The total number of hospital admissions, visits to the emergency department, and outpatient visits, stratified by language, including English, declined, or unavailable.

Inclusions:

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

Exclusions:

- Lab specimens and other types of registrations that have a medical record number but are not attached to patients that physically came to the hospital.

Data Elements:
Admissions
Visits

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required elements include administrative data and medical record documents.

Data Accuracy/Data Completeness: Variation may exist in data recording practices; therefore, data recording practices may require evaluation, monitoring and training to ensure consistency. Electronic data collection systems with drop down menus defaulting to *English* may increase the likelihood of error. Hospitals should consider screening for preferred written language for health care information at the point where a patient initially accesses health care in the hospital, emergency department, or ambulatory unit or clinic**.**

Measure Analysis Suggestions: Hospitals may want to develop drill down information for analysis with data reported by location.

Sampling: 100% of all admissions and patient visits.

Age groups: All.

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

Selected Literature:

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

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.

Hakimzadeh S, Cohn D. English usage among Hispanics in the United States. Pew Hispanic Center, The Henry J. Kaiser Family Foundation. 2007.

Pew Hispanic Center. Bilingualism (Survey brief). The Henry J. Kaiser Foundation. March 2004.

Data Abstraction Guidelines

Measure: L1B: *Screening for preferred written language for health care information.*

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 written language for health care information 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 written language for health care information may be taken.
- If electronic systems pre-populate the language preference field, credit for screening for preferred written language for health care information 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 written language for health care information may <u>not</u> be taken.
- If the patient's preferred spoken language for health care is recorded and the preferred written language for health care information is not recorded, credit for screening written language may <u>not</u> be taken.

Notes:

- All patients should be asked preferred written language for health care information. The goal is for the patient, not the provider or registration/scheduling staff, to self-identify preferred written language for health care information.
- Suggested screening question: "In which language do you prefer to read written health care information?"
- Braille should be included as a preferred written language for health care information for this measure.
- Organizational policy should specify whose preferred written language for health care information should be documented for pediatric patients and for incapacitated adults.
    - *For example*, Organizational policy may require that the preferred written language for health care information for a parent, family member or caregiver be 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 written language for health care information 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.

Inclusions and Exclusions:

	Numerator	**Denominator**
Inclusions	• Admissions and/or visits where the patient's preferred written language for health care information is recorded. • Admissions and/or visits where the patient declined to answer the screening question.	• Scheduled and unscheduled visits. • Elective, urgent and emergent admissions. • Short stay and observation patients. • Transfers from other facilities.
Exclusions	• Admissions and/or visits where the patient's written language preference for health care information is not recorded.	• Lab specimens and other types of registrations that have a medical record number but are not attached to patients that physically came to the hospital.

Measure Information Form

Measure Set: Language Services

Performance Measure ID: L2

Performance Measure Name: Patients receiving language services supported by qualified language service providers.

Domains of Quality: *Effectiveness, Equity, Patient-centeredness*

Description: The percent of limited English-proficiency (LEP) patients receiving **both** initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency.

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

Type of Measure: Process. The process of providing language services to patients at key points in their care (e.g., initial assessment and discharge).

Improvement Noted As: An increase in the percent of patients who receive **both** the initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency.

Numerator Statement(s): The number of LEP patients with documentation they received **both** the initial assessment and discharge instructions supported by assessed and trained interpreters, or from bilingual providers and bilingual workers/employees assessed for language proficiency, stratified by language.

Inclusions:

- Patients receiving **both** initial assessment and discharge instructions supported by:
  - Assessed and trained interpreters; or,
  - Bilingual providers or bilingual workers/employees assessed for language proficiency.

Exclusions:

- Patients receiving initial assessment and/or discharge instructions supported by interpreters who have not met the organization's assessment and training requirements.
- Patients receiving initial assessment and/or discharge instructions from a bilingual provider or bilingual worker/employee who has not met the organization's assessment requirements.
- Patients receiving initial assessment and/or discharge instructions supported by family or friends.

- There is no documentation indicating provision of qualified language services provided at initial assessment and/or during discharge instructions.

Data Elements*:*
Preferred spoken language for health care
Initial assessment
Discharge instructions
Initial assessment with bilingual provider or worker/employee assessed for language proficiency
Discharge instructions with bilingual provider or bilingual *worker/employee assessed for language proficiency*
Interpreter
Bilingual provider
Bilingual worker/employee
Initial assessment with assessed and trained interpreter
Discharge instructions with assessed and trained interpreter

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

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

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

Data Elements*:*
Preferred spoken language for health care
Initial assessment

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required elements include interpreter services department logs, medical records, and telephone vendor reports.

Data Accuracy/Data Completeness: Hospitals may want to work with clinical staffs to develop a documentation process to record how the language need was met. Variation may exist in data recording practices; therefore, data recording practices may require evaluation, monitoring and training to ensure consistency.

Measure Analysis Suggestion: Hospitals may want to further collect and examine data by location and by interpreter, bilingual provider, bilingual worker/employee, family/friend, or no documentation to show clinical staff how language needs are met.

Sampling: 100% of LEP patients.

Age Groups: All.

Data Reported As: Aggregate numerator(s) and denominator, monthly, stratified by language.

Selected Literature:

Betancourt, J. R., Jacobs, E. A. Language barriers to informed consent and confidentiality: the impact on women's health. *J. Am. Med. Womens Assoc.* 2000; 55: 294-295.

Diamond, L.C., Schenker, Y., Curry, L., Bradley, E., Fernandez, A. Getting by: Underuse of interpreters by resident physicians. *J Gen Intern Med*. 2009; 24(2): 256-62.

Elderkin-Thompson V, Silver RC, Waitzkin H. When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting. *Soc Sci Med.* 2001; 52:1343–1358.

Ferguson, W. Un Poquito *Health Affairs.* November/December 2008; 27(6): 1695-1700.

Flores, G. Language barriers to health care in the United States. *NEJM*. July 20, 2006; 355:229-231

Flores, G., Laws MD, Mayo SJ et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. 2003; 116: 6-14.

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

Guidance to federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons. *Federal Register*. June 8, 2002; 76(117): 41455-41472.

Jacobs, E., Lauderdale, D., Meltzer, D., Shorey, J., Levinson, W., Thistead, R. Impact of interpreter services on delivery of health care to limited-English-proficient patients. *J Gen Intern Med*. 2001; 16(7): 468–474.

Schenker, Y., Lo, B., Ettinger, K.M., Fernandez, A. Navigating language barriers under difficult circumstances. *Ann Intern Med.* 2008; 264-269.

Schyve PM. Language differences as a barrier to quality and safety in health care: the Joint Commission perspective. *J Gen Intern Med.* 2007;22 Suppl 2:360-1.

Data Abstraction Guidelines

Measure: L2: *Patients receiving language services supported by qualified language services providers*

Data Reported As: Aggregate numerator(s) and denominator, monthly, stratified by language.

Hospitals will report the numerator in three (3) parts:

Numerator 2A:

- Count the number of LEP patients who received the initial assessment supported by a qualified language services provider.
- Stratify by language.

Numerator 2B:

- Count the number of LEP patients who received discharge instructions supported by a qualified language services provider.
- Stratify by language.

Numerator 2C:

- Count the number of LEP patients who received both the initial assessment **AND** discharge instructions supported by a qualified language services provider.
- Stratify by language.

Denominator:

- Count the number of patients that stated a preference to receive their spoken health care in a language other than English.
- Stratify by language.

Notes for Abstraction:

- If the patient expires after the initial assessment but prior to discharge instructions, credit may be taken for discharge instruction.
- If the patient leaves against medical advice after the initial assessment but prior to the discharge instructions, credit may be taken for discharge instruction.
- If the patient is transferred out to another hospital or nursing home, credit may be taken for discharge instruction.
- If the interpreter used at the initial assessment is not qualified (i.e., has not met the organization's assessment and training requirements), credit may not be taken for initial assessment.
- If the bilingual provider or other bilingual worker/employee used at the initial assessment is not qualified (i.e., has not met the organization's language proficiency assessment requirements), credit may not be taken for initial assessment.
- If the interpreter used at the discharge instructions is not qualified (i.e., has not met the organization's assessment and training requirements), credit may not be taken for discharge instruction.
- If the bilingual provider or other bilingual worker/employee used at the discharge instructions is not qualified (i.e., has not met the organizations language proficiency assessment requirements), credit may not be taken for discharge instruction.
- If the patient refuses an interpreter at initial assessment, credit may be taken for initial assessment.

- If the patient refuses an interpreter for discharge instructions, credit may be taken for discharge instructions.
- Some organizations use contract and/or agency interpreters and/or remote vender interpreters (i.e., telephone and/or video) to provide language services to patients. If such interpreters have not met the organization's assessment and training requirements, credit may not be taken.
    - *Please note:* If an organization uses contract, agency, and/or remote interpreters and the contracts with the language services vendors specify the assessment and training qualifications of the interpreters, those specifications (from the contract) may be used to determine contract and/or agency interpreters and remote vendor interpreter qualifications.
- If there is no documentation of interpreter or bilingual provider or other bilingual worker/employee use at initial assessment and/or at discharge instruction, credit may not be taken.
- If the family or friend were used in lieu of a qualified interpreter or qualified bilingual provider or other bilingual worker/employee at initial assessment and/or at discharge instruction, credit may not be taken.

Notes:

- Reliance on documentation of language services provision from interpreters alone may be incomplete as interpreter documentation is unlikely to include outside vendor telephone or video services or when bilingual providers, family members, and friends are used.

Inclusions and Exclusions:

	Numerator	Denominator
Inclusions	Patients receiving **both** initial assessment and discharge instructions supported by: • Assessed and trained interpreters; or, • Bilingual providers or bilingual workers/employees assessed for language proficiency.	• All patients stating a preference to receive spoken health care in a language other than English.
Exclusions	• Patients receiving initial assessment and/or discharge instructions supported by interpreters who have not met the organization's assessment and training requirements. • Patients receiving initial assessment and/or discharge instructions from a bilingual provider or worker/employee who has not met the organization's assessment requirements. • Patients receiving initial assessment and/or discharge instructions supported by family or friends. • There is no documentation indicating provision of qualified language services provided at initial assessment and/or discharge instructions.	• All patients stating a preference to receive spoken health care in English. • Patients who leave without being seen. • Patients who leave against medical advice prior to the initial assessment.

Assessment and Training Information

Measure: L2: *Patients receiving language services supported by qualified language services providers*

Title: *Interpreters, Bilingual Providers and Bilingual Workers/Employees Language Proficiency Assessment and Training*

Description: Interpreters, Bilingual Providers and Bilingual Workers/Employees assessment and training information

Rationale: Assessment and training information about an organization's interpreter, bilingual provider and bilingual worker/employee workforce are needed to determine whether limited English-proficiency (LEP) patients received language services from qualified language services providers. The information is also useful to managers in determining and planning the education and training needs of staff.

Information Reported As: While not a measure, the following information should be collected for interpreters, bilingual providers and other bilingual workers/employees. This information should be updated periodically and include all persons providing spoken language services and American Sign Language services to patients at the organization:

Information Collected About Interpreters:

- The total number of interpreters, stratified by language.
- The number of interpreters trained in medical interpreting methodologies/strategies.
- The number of interpreters assessed for language proficiency in language(s) for which they interpret.
- The number of interpreters both assessed and trained.

Notes:

- Interpreter Language Proficiency Assessment requirements are what the organization's policy has defined as requirements for interpreter assessment and training.
- An individual interpreter should be evaluated for each language they interpret.
    - *For example*, if Interpreter X interprets for both Spanish and Russian patients, the organization should determine whether assessment and training requirements have been met for both Spanish and Russian languages.

Information Collected About Bilingual Providers and Bilingual Workers/Employees:

- The total number of bilingual providers and other bilingual workers/employees, stratified by language.
- The number of bilingual providers and other bilingual workers/employees assessed for language proficiency in each language they speak with patients.

Notes:

- Bilingual Providers and Bilingual Workers/Employees Language Proficiency Assessment requirements are what the organization's policy has defined as requirements for bilingual provider and bilingual workers/employees assessment.
- An individual bilingual provider or other bilingual worker/employee should be assessed for each language they speak with patients.

- *For example*, if Dr. X speaks for both Spanish and Russian with patients, the organization should determine whether language proficiency requirements have been met for both Spanish and Russian languages.

Measure Information Form

Measure Set: Language Services

Performance Measure ID: L3

Performance Measure Name: Patient wait time to receive interpreter services.

Description: The percent of encounters where the wait time for an interpreter is 15 minutes or less.

Domains of Quality: *Effectiveness, Patient-centeredness, Timeliness*

Rationale: Patients and providers report resistance or reluctance in using interpreter services due to long wait times or delays in obtaining an interpreter upon request. As interpreter services continue to evolve, many hospitals across the country have adopted standards for wait times for interpreter encounters. This measure provides information on the extent to which interpreter services are able to respond to requests for service within a reasonable amount of time, defined here as within 15 minutes.

Type of Measure: Process. The process used to deliver interpreter services to patients.

Improvement Noted As: An increase in the percent of encounters in which the wait time is 15 minutes or less for the interpreter to arrive

Numerator Statement: The number of interpreter encounters in which the wait time is 15 minutes or less for the interpreter to arrive, stratified by language.

Inclusions*:*

- On-site interpreter encounters with hospital operated interpreters and/or on-site contract and/or agency interpreters.
- Hospital operated telephone interpreters.
- Hospital operated video interpreters.
- Scheduled and unscheduled interpreter encounters.

Exclusions:

- Encounters where the wait time is greater than 15 minutes for interpreter to arrive.
- Encounters with bilingual providers and/or other bilingual hospital workers/employees.
- Encounters with outside vendor telephone interpreters and/or outside vendor video interpreters.

Data Elements:
Interpreter encounters
Time interpreter requested
Time interpreter arrived
Preferred spoken language for health care

Denominator Statement: The total number of interpreter encounters, stratified by language.

Inclusions:
- On-site interpreter encounters with hospital operated interpreters and/or on-site contract and/or agency interpreters.
- Hospital operated telephone interpreters.
- Hospital operated video interpreters.
- Scheduled and unscheduled interpreter encounters.

Exclusions:
- Encounters with bilingual providers and/or other bilingual workers/employees.
- Encounters with outside vendor telephone interpreters.
- Encounters with outside vendor video interpreters.

Data Elements:
Preferred spoken language for health care
Interpreter encounters

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required elements include interpreter services department logs and medical records.

Data Accuracy/Data Completeness: Variation may exist in data recording practices; therefore, data recording practices may require evaluation, monitoring and training to ensure consistency.

Measure Analysis Suggestions: Hospitals may want to design reporting systems to examine rates by location, by interpreter, by mode of interpreting, by scheduled and unscheduled encounters**.**

Sampling: 100% interpreter encounters.

Age Groups: All.

Data Reported As: Aggregate numerator and denominator, monthly, stratified by language.

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

Regenstein M, Huang J, West C, Trott J, Stegun M. Hospital language services: quality improvement and performance measures. Advances in patient safety: new directions and alternative approaches. Vol. 1-4. Rockville (MD): Agency for Healthcare Research and Quality; 2008 Jul. (AHRQ publication; no. 08-0034)

Data Abstraction Guidelines

Measure: L3: *Patient wait time to receive interpreter services*

Data Reported As: Aggregate numerator and denominator, monthly, stratified by language.

Numerator:

- Calculate the difference between the time the *interpreter was requested* and the *time the interpreter* arrived.
- Apply inclusions and exclusions.
- Count the number of times where the difference was 15 minutes or less.
- Stratify by language.

Denominator:

- Count the total number of interpreter encounters.
- Apply inclusions and exclusions.
- Stratify by language.

Notes for Abstraction:

- If there is no documentation of *time interpreter requested* and/or *time the interpreter arrived*, credit may not be taken.
- For unscheduled encounters, *time interpreter requested* is the time when a provider, patient, clinic professional, and/or any other person initiated a request for an interpreter.
    - The request can be in the form of a written order, an electronic order, a verbal request, or a phone call directly to an interpreter and/or department.
    - *For example*, if a nurse calls the interpreter services department at 1410 to request an interpreter for discharge instructions, then the *time interpreter requested* is 1410.
- For scheduled encounters, *time interpreter requested* is the scheduled time for the interpreter encounter.
    - The request can be in the form of a written order, an electronic order, a verbal request, or a phone call directly to an interpreter or department.
    - *For example*, if the outpatient clinic notifies the interpreter services department via electronic order that an interpreter is needed in 2 days at 0915, then the *time interpreter requested* is 0915.
- For remote interpreting methods (i.e., interpreting via telephone or video), *time interpreter requested* is the time initial verbal contact is made with hospital operated telephone interpreting or hospital operated video interpreting to make the interpreter request.
    - *For example*, the doctor dials the number for the hospital operated telephone interpreter. If a representative answers the phone at 2020, then the *time interpreter requested* is 2020.
- The *time interpreter arrived* is the time when an interpreter reaches the location where interpreting will occur.
    - For example, if the interpreter arrives in the Emergency Department at 1240 for an encounter, then the *time interpreter arrived* is 1240.
- For remote interpreting methods (i.e., interpreting via hospital operated telephone interpretiers or hospital operated video interpreters), *time interpreter arrived* is the time the interpreter is connected.

- *For example*, the doctor dials the number for a hospital operated telephone interpreter. If a representative takes the interpreter request at 2020 and the interpreter is connected at 2024, then the *time interpreter arrived* is 2024.

Notes:

- Organizations may need to work with contract and/or agency interpreter vendors to set expectations for providing *time interpreter arrived* documentation.

Inclusions and Exclusions:

	Numerator	**Denominator**
Inclusions	• On-site interpreter encounters with hospital operated interpreters, and on-site contract and/or agency interpreters. • Hospital operated telephone interpreters. • Hospital operated video interpreters. • Scheduled and unscheduled interpreter encounters.	• On-site interpreter encounters with hospital operated interpreters, and on-site contract and/or agency interpreters. • Hospital operated telephone interpreters. • Hospital operated video interpreters. • Scheduled and unscheduled interpreter encounters.
Exclusions	• Encounters where the wait time is greater than 15 minutes for interpreter to arrive. • Encounters with bilingual providers and/or other bilingual hospital workers/employees. • Encounters with outside vendor telephone interpreters and/or outside vendor video interpreters.	• Encounters with bilingual providers and/or other bilingual workers/employees. • Encounters with outside vendor telephone interpreters • Encounters with outside vendor video interpreters.

Measure Information Form

Measure Set: Language Services

Performance Measure ID: L4

Performance Measure Name: Interpreter wait time to deliver interpreter services.

Description: The percent of interpreter encounters where interpreters wait time to provide interpreter services to provider and patient is 15 minutes or less.

Domains of Quality: *Effectiveness, Timeliness*

Rationale: Interpreters are frequently in high demand at hospitals providing care to diverse patient populations, and as a result, must closely monitor their time spent in non-interpretation activities. Interpreter services staff must work with provider and clinic staff to ensure successful coordination of provider's schedules with interpreter schedules. This measure provides information on the extent to which interpreters spend time waiting to provide interpreter services for a provider and patient, creating delays for other interpreter services encounters and diminishing productivity.

Type of Measure: Process. The process used to deliver interpreter services to patients.

Improvement Noted As: An increase in the percentage of encounters where interpreters wait time to provide interpreter services to provider and patient is 15 minutes or less.

Numerator Statement: The number of interpreter encounters in which the interpreter wait time to begin interpreting is 15 minutes or less, stratified by language.

Inclusions:

- On-site interpreter encounters with hospital operated interpreters or on-site contract and/or agency interpreters.
- Encounters with hospital operated telephone interpreters and/or hospital operated video interpreters.
- Scheduled and unscheduled interpreter encounters.

Exclusions:

- Any interpreter encounter where an interpreter waits more than 15 minutes to begin interpreting.
- Encounters with bilingual providers and/or other bilingual hospital workers/employees.
- Outside vendor telephone interpreters and/or outside vendor video interpreters.

Data Elements:

Interpreter encounters
Time interpreter arrived
Encounter start time
Preferred spoken language for health care

Denominator Statement: The total number of interpreter encounters, stratified by language.

Inclusions:
- On-site interpreter encounters with hospital operated interpreters or on-site contract and/or agency interpreters.
- Encounters with hospital operated telephone interpreters and/or hospital operated video interpreters.
- Scheduled and unscheduled interpreter encounters.

Exclusions:
- Encounters with bilingual providers and/or other bilingual hospital workers/employees.
- Outside vendor telephone interpreters and/or outside vendor video interpreters.

Data Elements:
Preferred spoken language for health care
Interpreter encounters

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required elements include interpreter services department data logs and medical records.

Data Accuracy/Data Completeness: Variation may exist in data recording practices; therefore, data recording practices may require evaluation, monitoring and training to ensure consistency.

Measure Analysis Suggestions: Hospitals may want to design reporting systems to examine rates by location, by language, by interpreter, by mode of interpreting, by scheduled and unscheduled encounters.

Sampling: 100% interpreter services encounters.

Age Groups: All.

Data Reported As: Aggregate numerator and denominator, monthly, stratified by language.

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

Regenstein M, Huang J, West C, Trott J, Stegun M. Hospital language services: quality improvement and performance measures. Advances in patient safety: new directions and alternative approaches. Vol. 1-4. Rockville (MD): Agency for Healthcare Research and Quality; 2008 Jul. (AHRQ publication; no. 08-0034)

Data Abstraction Guidelines

Measure: L4: *Interpreter wait time to deliver interpreter services*

Data Reported As: Aggregate numerator and denominator, monthly, stratified by language.

Numerator:

- Calculate the difference between the *time interpreter arrived* and the *encounter start time*.
- Then count the number where the difference was 15 minutes or less.
- Apply inclusions and exclusions.
- Stratify by language.

Denominator:

- Count the total number of interpreter encounters.
- Apply inclusions and exclusions.
- Stratify by language.

Notes for Abstraction:

- If there is no documentation of *time the interpreter arrived* and/or *encounter start time,* credit may not be taken.
- The *time interpreter arrived* is the time when an interpreter reaches the location where interpreting will occur.
    - For example, if the interpreter arrives in the Emergency Department at 1240 for an encounter, then the *time interpreter arrived* is 1240.
- For hospital operated remote interpreting methods (e.g., interpreting via hospital operated telephone interpreters and/or hospital operated video interpreters), the *time interpreter arrived* is the time the interpreter is connected.
    - *For example*, if the doctor dials the number for a hospital operated telephone interpreter and a representative takes the interpreter request at 2020 and the interpreter is connected at 2024, then the *time interpreter arrived* is 2024.
    - *For example,* if the doctor dials the number at 2020 and is immediately connected to the interpreter, the *time interpreter arrived* is 2020.
- The *encounter start time* is the time when the interpreter begins interpreting for the patient and hospital providers and/or staff.
    - *For example*, if the interpreter arrives in the ICU, goes into the patient room with the nurse at 1505 and immediately begins interpreting what the nurse is saying to the patient, then the *encounter start time* is 1505.
- For encounters with a pre-session: The *encounter start time* is the time when the provider and interpreter meet to discuss the case immediately prior to joining the patient.
    - *For example*, if the interpreter arrives in the ICU and the nurse and interpreter begin discussing the case without the patient at 1500 and at 1505 go into the patient's room where the interpreter begins interpreting what the nurse is saying to the patient, then the *encounter start time* is 1500.

Notes:

- Organizations may need to work with on-site contract and/or agency interpreter vendors to set expectations for providing time *interpreter arrived* and *encounter start time* documentation.

Inclusions and Exclusions:

	Numerator	Denominator
Inclusions	• On-site interpreter encounters with hospital operated interpreters or on-site contract and/or agency interpreters. • Encounters with hospital operated telephone interpreters and/or hospital operated video interpreters. • Scheduled and unscheduled interpreter encounters.	• On-site interpreter encounters with hospital operated interpreters, or on-site contract and/or agency interpreters. • Encounters with hospital operated telephone interpreters and/or hospital operated video interpreters. • Scheduled and unscheduled interpreter encounters.
Exclusions	• Any interpreter encounter where an interpreter waits more than 15 minutes to begin interpreting. • Encounters with bilingual providers and/or other bilingual hospital workers/employees. • Outside vendor telephone interpreters and/or outside vendor video interpreters.	• Encounters with bilingual providers and/or other bilingual hospital workers/employees. • Outside vendor telephone interpreters and/or outside vendor video interpreters.

Measure Information Form

Measure Set: Language Services

Performance Measure ID: L5

Performance Measure Name: Time spent interpreting.

Description: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers.

Domains of Quality: *Effectiveness*

Rationale: Interpreters frequently spend much of their time involved in administrative and logistics-related activities, such as scheduling, travel, and recording information about their interpreter encounters. This measure provides information on the extent to which hospital operated interpreters are able to devote their time to providing interpretation in clinical encounters with patients and providers. This measure also provides managers with data to calculate cost and efficiency-related information.

Type of Measure: Process. The process of providing effective and efficient staffing levels.

Improvement Noted As: An increase in the percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers.

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

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, 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

Preferred spoken language for health care

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

Inclusions:
- Hospital operated on-site interpreters.
- Hospital operated telephone interpreters.
- Hospital operated video interpreters.

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.

Data Elements:
Minutes worked
Preferred spoken language for health care

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, 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.

Sampling: 100% interpreter encounters.

Age groups: All.

Data Reported As: Aggregate numerator and denominator, in minutes, monthly, stratified by language.

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

Regenstein M, Huang J, West C, Trott J, Stegun M. Hospital language services: quality improvement and performance measures. Advances in patient safety: new directions and alternative approaches. Vol. 1-4. Rockville (MD): Agency for Healthcare Research and Quality; 2008 Jul. (AHRQ publication; no. 08-0034)

Data Abstraction Guidelines

Measure: L5: *Time spent interpreting*

Data Reported As: Aggregate numerator and denominator, in minutes, monthly, stratified by language.

Numerator:
- Sum the total number of minutes interpreters spent providing interpretation during clinical encounters during the calendar month.
- Apply inclusions and exclusions.
- Stratify by language.

Denominator:
- Sum the total number of minutes worked by interpreters during the calendar month.
- Apply inclusions and exclusions.
- Stratify by language.

Notes for Abstraction:
- If there is no documentation of *encounter start time* and/or *encounter end time*, credit may not be taken.
- The *encounter start time* is the time when the interpreter begins interpreting for the patient and hospital providers or staff.
  - *For example*, if the interpreter arrives in the ICU, goes into the patient room with the nurse at 1505 and immediately begins interpreting what the nurse is saying to the patient, then the *encounter start time* is 1505.
- For clinical encounters with a pre-session: Use the time when the provider and interpreter meet to discuss the case immediately prior to including the patient.
  - *For example*, if the interpreter arrives in the ICU and the nurse and interpreter begin discussing the case without the patient at 1500 and at 1505 go into the patient's room where the interpreter begins interpreting what the nurse is saying to the patient, then the *encounter start time* is 1500.
- The *encounter end time* is the time when the interpreter stops interpreting for the patient and hospital staff or provider.
- For clinical encounters with a post-session: Use the time when the interpreter and provider meet to discuss the case (without the patient) immediately following clinical encounter with the interpreter, provider and patient.
  - *For example*, if the nurse and interpreter leave the patient at 1515 and they continue to discuss the case without the patient concluding their discussion at 1520, then the *encounter end time* is 1520.

Notes:
- The measure is reported for *clinical encounters* only.
- This measure is reported in minutes.
- The results from this measure may give organizations better insight into how much time interpreters spend in non-clinical encounters and activities (e.g., travel time, waiting, way-finding, billing issues, etc).

Inclusions and Exclusions:

	Numerator	Denominator
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.	• Hospital operated on-site interpreters. • Hospital operated telephone interpreters. • Hospital operated video interpreters.
Exclusions	• Non-clinical interpreter encounters, e.g., billing issues, need to interpret patient meal preferences, parking instructions, etc. • Encounters with bilingual providers and other bilingual hospital workers/employees. • Outside vendor telephone interpreters and outside vendor video interpreters. • Agency and contract interpreters.	• 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.

Set Measure	Description	Numerator	Denominator
L1A: Screening for preferred spoken language for health care.	The percent of patients' visits and admissions where preferred spoken language for health care is screened and recorded.	The number of hospital admissions, visits to the emergency department, and outpatient visits where preferred spoken language for health care is screened and recorded, stratified by language, including English, declined, or unavailable. **Numerator:** *Inclusions:* • Admissions and/or visits where the patient's preferred spoken language for health care is recorded. • Admissions and/or visits where the patient declined to answer the screening question. *Exclusions:* • Admissions and/or visits where the patient's spoken language preference for health care is not recorded.	The total number of hospital admissions, visits to the emergency department, and outpatient visits, stratified by language, including English, declined, or unavailable. **Denominator:** *Inclusions:* • Scheduled and unscheduled visits. • Elective, urgent and emergent admissions. • Short stay and observation patients. • Transfers from other facilities. *Exclusions:* • Lab specimens and other types of registrations that have a medical record number but are not attached to patients that physically came to the hospital.
L1B: Screening for preferred written language for health care information.	The percent of patients' visits and admissions where preferred written language for health care information is screened and recorded.	The number of hospital admissions, visits to the emergency department, and outpatient visits where preferred written language for health care information is screened and recorded, stratified by language, including English, declined, or unavailable. **Numerator:** *Inclusions:* • Admissions and/or visits where the patient's preferred written language for health care information is recorded. • Admissions and/or visits where the patient declined to answer the screening question. *Exclusions:* • Admissions and/or visits where the patient's written language preference for health care information is not recorded.	The total number of hospital admissions, visits to the emergency department, and outpatient visits, stratified by language, including English, declined, or unavailable. **Denominator:** *Inclusions:* • Scheduled and unscheduled visits. • Elective, urgent and emergent admissions. • Short stay and observation patients. • Transfers from other facilities. *Exclusions:* • Lab specimens and other types of registrations that have a medical record number but are not attached to patients that physically came to the hospital.

Set Measure	Description	Numerator	Denominator
L2: Patients receiving language services supported by qualified language service providers.	The percent of limited English-proficiency (LEP) patients receiving **both** initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency.	The number of LEP patients with documentation they received **both** the initial assessment and discharge instructions supported by assessed and trained interpreters, or from bilingual providers and bilingual workers/employees assessed for language proficiency, stratified by language. **Numerator:** *Inclusions:* • Patients receiving **both** initial assessment and discharge instructions supported by: o Assessed and trained interpreters; or, o Bilingual providers or bilingual workers/employees assessed for language proficiency. *Exclusions:* • Patients receiving initial assessment and/or discharge instructions supported by interpreters who have not met the organization's training and assessment requirements. • Patients receiving initial assessment and/or discharge instructions from a bilingual provider or bilingual worker/employee who has not met the organization's assessment requirements. • Patients receiving initial assessment and/or discharge instructions supported by family or friends. • There is no documentation indicating provision of qualified language services provided at initial assessment and/or during discharge instructions.	Total number of patients that stated a preference to receive their spoken care in a language other than English, stratified by language. **Denominator:** *Inclusions:* • All patients stating a preference to receive spoken health care in a language other than English. *Exclusions:* • All patients stating a preference to receive spoken health care in English. • Patients who leave without being seen. • Patients who leave against medical advice prior to the initial assessment.

Set Measure	Description	Numerator	Denominator
L3: Patient wait time to receive interpreter services.	The percent of encounters where the wait time for an interpreter is 15 minutes or less.	The number of interpreter encounters in which the wait time is 15 minutes or less for the interpreter to arrive, stratified by language. **Numerator:** *Inclusions:* • On-site interpreter encounters with hospital operated interpreters and/or on-site contract and/or agency interpreters. • Hospital operated telephone interpreters. • Hospital operated video interpreters. • Scheduled and unscheduled interpreter encounters. *Exclusions:* • Encounters where the wait time is greater than 15 minutes for interpreter to arrive. • Encounters with bilingual providers and/or other bilingual hospital workers/employees. • Encounters with outside vendor telephone interpreters and/or outside vendor video interpreters.	The total number of interpreter encounters, stratified by language. **Denominator:** *Inclusions:* • On-site interpreter encounters with hospital operated interpreters and/or on-site contract and/or agency interpreters. • Hospital operated telephone interpreters. • Hospital operated video interpreters. • Scheduled and unscheduled interpreter encounters. *Exclusions:* • Encounters with bilingual providers and/or other bilingual workers/employees. • Encounters with outside vendor telephone interpreters. • Encounters with outside vendor video interpreters

Set Measure	Description	Numerator	Denominator
L4: Interpreter wait time to deliver interpreter services.	The percent of interpreter encounters where interpreters wait time to provide interpreter services to provider and patient is 15 minutes or less.	The number of interpreter encounters in which the interpreter waits less than 15 minutes to begin interpreting, stratified by language. **Numerator:** *Inclusions:* • On-site interpreter encounters with hospital operated interpreters or on-site contract and/or agency interpreters. • Encounters with hospital operated telephone interpreters and/or hospital operated video interpreters. • Scheduled and unscheduled interpreter encounters. *Exclusions:* • Any interpreter encounter where an interpreter waits more than 15 minutes to begin interpreting. • Encounters with bilingual providers and/or other bilingual hospital workers/employees. • Outside vendor telephone interpreters and/or outside vendor video interpreters.	The total number of interpreter encounters, stratified by language. **Denominator:** *Inclusions:* • On-site interpreter encounters with hospital operated interpreters or on-site contract and/or agency interpreters. • Encounters with hospital operated telephone interpreters and/or hospital operated video interpreters. • Scheduled and unscheduled interpreter encounters. *Exclusions:* • Encounters with bilingual providers and/or other bilingual hospital workers/employees. • Outside vendor telephone interpreters and/or outside vendor video interpreters.

Set Measure	Description	Numerator	Denominator
L5: Time spent interpreting	The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers.	The total number of minutes interpreters spent providing interpretation during clinical encounters during the calendar month, stratified by language. **Numerator:** *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, parking instructions, etc. • Encounters with bilingual providers and other bilingual hospital workers/employees. • Outside vendor telephone interpreters and outside vendor video interpreters. • Agency and contract interpreters.	The total number of minutes worked by interpreters during the calendar month, stratified by language. **Denominator:** *Inclusions:* • Hospital operated on-site interpreters. • Hospital operated telephone interpreters. • Hospital operated video interpreters. *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.

Data Elements

Language Services Measures:
L1A: Screening for preferred spoken language for health care.
L1B: Screening for preferred written language for health care information.
L2: Patients receiving language services supported by qualified language service providers.
L3: Patient wait time to receive interpreter services.
L4: Interpreter wait time to deliver interpreter services.
L5: Time spent interpreting.

Data Element	Measure
Admissions	L1A, L1B
Bilingual provider	L2
Clinical encounters	L5
Discharge instructions	L2
Discharge instructions with bilingual provider or worker/employee assessed for language proficiency	L2
Discharge instructions with trained and assessed interpreter	L2
Encounter end time	L5
Encounter start time	L4, L5
Initial assessment	L2
Initial assessment with bilingual provider or worker/employee assessed for language proficiency	L2
Initial assessment with trained and assessed interpreter	L2
Interpreter	L2
Interpreter encounters	L3, L4, L5
Minutes worked	L5
Preferred spoken language for health care	L1A, L2, L3, L4, L5
Preferred written language for health care information	L1B
Time interpreter arrived	L3, L4
Time interpreter requested	L3
Visits	L1A, L1B

LQIC Measures:
L1A: Screening for preferred spoken language for health care.
L1B: Screening for preferred written language for health care information.
L2: Patients receiving language services supported by qualified language service providers.
L3: Patient wait time to receive interpreter services.
L4: Interpreter wait time to deliver interpreter services.
L5: Time spent interpreting.

Data Element	L1A	L1B	L2	L3	L4	L5
Admissions	X	X				
Bilingual provider			X			
Clinical encounters						X
Discharge instructions			X			
Discharge instructions with bilingual provider or worker/employee assessed for language proficiency			X			
Discharge instructions with trained and assessed interpreter			X			
Encounter end time						X
Encounter start time					X	X
Initial assessment			X			
Initial assessment with bilingual provider or worker/employee assessed for language proficiency			X			
Initial assessment with trained and assessed interpreter			X			
Interpreter			X			
Interpreter encounters				X	X	X
Minutes worked						X

Data Element	L1A	L1B	L2	L3	L4	L5
Preferred spoken language for health care	X		X	X	X	X
Preferred written language for health care information		X				
Time interpreter arrived				X	X	
Time interpreter requested				X		
Visits	X	X				

The following section contains data collection tools. Use of the tools is not required. Hospitals may use or modify existing data collection systems or create a new system to best meet individual needs.

TEMPLATE: LANGUAGE SERVICES PERFORMANCE MEASURES
DATA COLLECTION TOOL – L1A

L1A: Screening for preferred **spoken** language for health care.

Date	Admission or Visit	Screening Results		
		Preferred Spoken Language (includes sign language) (write the preferred language)	Decline (check if patient declined to answer)	Unavailable (check if information is not available)

INSTRUCTIONS and EXAMPLES: LANGUAGE SERVICES PERFORMANCE MEASURES
DATA COLLECTION TOOL – L1A

L1A: Screening for preferred **spoken** language for health care.

Date	Admission or Visit	Screening Results		
		Preferred Spoken Language (includes sign language) (write the preferred language)	Decline (check if patient declined to answer)	Unavailable (check if information is not available)
Enter patient admission or visit date	Write the medical record number of Admission or Visit	If provided, record the written language preference. †	Check if the patient declined to answer. †	Check if the information is not available. †
7/17/2009	12345678	English		
7/17/2009	23456789			✓
7/18/2009	34567890	Spanish		
7/18/2009	12345678	English		
7/19/2009	56789012	ASL		
7/21/2009	67890123	Russian		
7/23/2009	78901234		✓	

† Please note: only one (1) box should be completed.

TEMPLATE: LANGUAGE SERVICES PERFORMANCE MEASURES
DATA COLLECTION TOOL – L1B

L1B: Screening for preferred **written** language for health care.

Date	Admission or Visit	Screening Results		
		Preferred Written Language (includes Braille) (write the preferred language)	Decline (check if patient declined to answer)	Unavailable (check if information is not available)

INSTRUCTIONS and EXAMPLE: LANGUAGE SERVICES PERFORMANCE MEASURES
DATA COLLECTION TOOL – L1B

L1B: Screening for preferred **written** language for health care.

Date	Admission or Visit	Screening Results		
		Preferred Written Language (includes Braille) (write the preferred language)	Decline (check if patient declined to answer)	Unavailable (check if information is not available)
Enter patient admission or visit date	Write the medical record number of Admission or Visit	If provided, record the written language preference. †	Check if the patient declined to answer. †	Check if the information is not available. †
7/17/2009	12345678	English		
7/17/2009	23456789			✓
7/18/2009	34567890	Spanish		
7/18/2009	12345678	English		
7/19/2009	56789012	Arabic		
7/21/2009	67890123	Russian		
7/23/2009	78901234		✓	

† Please note: only one (1) box should be completed.

TEMPLATE: LANGUAGE SERVICES PERFORMANCE MEASURES
DATA COLLECTION TOOL – L2

L2: Patients receiving language services supported by qualified language service providers.

LEP Patient	Spoken Language Preference	Initial Assessment						Discharge Instructions					
		Interpreter Name	Bilingual Provider Name	Bilingual Worker/ Employee Name	Family / Friend	Unknown	Qualified	Interpreter Name	Bilingual Provider Name	Bilingual Worker/ Employee Name	Family / Friend	Unknown	Qualified

INSTRUCTIONS and TEMPLATE: LANGUAGE SERVICES PERFORMANCE MEASURES
DATA COLLECTION TOOL – L2

L2: Patients receiving language services supported by qualified language service providers.

LEP Patient	Spoken Language Preference	Initial Assessment						Discharge Instructions					
		Interpreter Name	Bilingual Provider Name	Bilingual Worker/ Employee Name	Family / Friend	Unknown	Qualified	Interpreter Name	Bilingual Provider Name	Bilingual Worker/ Employee Name	Family / Friend	Unknown	Qualified
LEP Patient Name	Patient's spoken language preference	Name, if used.	Name, if used.	Name, if used.	Check, if used.	Check, if no record kept	†	Name, if used.	Name, if used.	Name, if used.	Check, if used.	Check, if no record kept	†
		Name of person used for initial assessment. Select 1 from the 4 categories						Name of person used for initial assessment. Select 1 from the 4 categories					
Cathy West	French				X		No					X	No
Jenny Huang	Taiwanese	M. Smith					Yes	Roger Lin					Yes
Vickie Sears	Hmong		Jorge Ramirez				No	David Yi					Yes
Mariza Hardin	Hmong			Joan Meehan			No	Gina Davis					Yes
John Doe	Arabic					X	No		Betsy James				Yes
Mary Jannie	Spanish	Juan Santos					Yes	Juan Santos					Yes
Lisa Flores	Spanish	Juan Santos					Yes				X		No

†: Write Yes if the person supporting initial assessment or discharge instructions met the hospital's training and assessment requirements for language services. If not, write No.

TEMPLATE: LANGUAGE SERVICES PERFORMANCE MEASURES TRAINING AND ASSESSMENT INFORMATION – L2 ASSESSMENT AND TRAINING INFORMATION– INTERPRETER

Language interpreted	Interpreter name	Trained in medical interpreting methodologies / strategies Yes / No	Assessed for proficiency for each language they interpret Yes / No	Interpreter Trained AND Assessed Yes / No

INSTRUCTIONS and EXAMPLE: LANGUAGE SERVICES PERFORMANCE MEASURES TRAINING AND ASSESSMENT INFORMATION – L2 ASSESSMENT AND TRAINING INFORMATION – INTERPRETER

Language interpreted	Interpreter name	Trained in medical interpreting methodologies / strategies Yes / No	Assessed for proficiency for each language they interpret Yes / No	Interpreter Trained AND Assessed Yes / No
List all the languages interpreted	List names of interpreter next to the language(s) they interpret (column to the left) †	If the interpreter was assessed for proficiency - indicate yes† If the interpreter was not assessed for proficiency - indicate no. †	If the interpreter was trained in medical interpreting methodologies / strategies - indicate yes† If the interpreter was not trained in medical interpreting methodologies / strategies - indicate no. †	If there is a "Yes" in the two columns to the left - indicate Yes
Spanish	Mary Smith	Y	Y	Y
Spanish	Cathy West	N	Y	N
Hmong	Marsha Regenstein	Y	Y	Y
Hmong	Marcia Wilson	Y	Y	Y
Haitian Creole	Donna Sickler	N	N	N
Haitian Creole	Mike West	N	Y	N
Portuguese	Michael West	Y	Y	Y
Portuguese	Bruce Siegel	Y	Y	Y
Russian	Cathy West	Y	N	N

† An individual interpreter will be listed more than 1 time if they interpret more than 1 language.

TEMPLATE: LANGUAGE SERVICES PERFORMANCE MEASURES ASSESSED FOR LANGUAGE PROFICIENCY– L2 ASSESSMENT AND TRAINING INFORMATION – BILINGULAL PROVIDER AND BILINGUAL WORKER / EMPLOYEE

Language	Bilingual Provider OR Bilingual Worker / Employee	Assessed for language proficiency Yes / No

INSTRUCTIONS and EXAMPLE: LANGUAGE SERVICES PERFORMANCE MEASURES ASSESSED FOR LANGUAGE PROFICIENCY– L2 ASSESSMENT AND TRAINING INFORMATION – BILINGULAL PROVIDER AND BILINGUAL WORKER / EMPLOYEE

Language	Bilingual Provider OR Bilingual Worker / Employee	Assessed for language proficiency Yes / No
List all the languages interpreted	List names of Bilingual provider next to the language(s) they interpret (column to the left) †	If the bilingual provider was assessed for language proficiency - indicate yes† If the bilingual provider was not assessed for language proficiency - indicate no†
Spanish	M. Jones, RN	Y
Spanish	C. West, RN	N
Spanish	J, Huang, RN	Y
Hmong	V. Sears, RN	Y
Hmong	M. Smith MD	Y
Hmong	M. Ross, MD	Y
Haitian Creole	H. Lee, PhD	N
Haitian Creole	J. Trott, MD	N
Haitian Creole	D. Flores, MSW	N
Haitian Creole	M. Gray RN	N
Portuguese	M. Thomas, RN	Y
Portuguese	B. Sims, MD	Y
Portuguese	L. Vasari, RD	Y

† An individual bilingual provider will be listed more than 1 time if they speak more than 1 language.

TEMPLATE: LANGUAGE SERVICES PERFORMANCE MEASURES
DATA COLLECTION TOOL – L3, L4, L5

L3: Patient wait time to receive interpreter services.
L4: Interpreter wait time to deliver interpreter services.
L5: Time spent interpreting.

LEP Patient Name	Language Interpreted	Time Interpreter Requested	Time interpreter Arrived	Encounter Start Time	Encounter End Time	Encounter Type: ▪ Initial Assessment ▪ Discharge Instruction ▪ Other

INSTRUCTIONS and EXAMPLE: LANGUAGE SERVICES PERFORMANCE MEASURES
DATA COLLECTION TOOL – L3, L4, L5

L3: Patient wait time to receive interpreter services.
L4: Interpreter wait time to deliver interpreter services.
L5: Time spent interpreting.

LEP Patient Name	Language Interpreted	Time Interpreter Requested	Time interpreter Arrived	Encounter Start Time	Encounter End Time	Encounter Type: ▪ Initial Assessment ▪ Discharge Instruction ▪ Other
Write LEP patient name	Write the language interpreted	†	Write the time interpreter arrived	What time did the encounter start?	What time did the encounter end?	Indicate if interpreted for an Initial Assessment: Discharge Instruction; or Other
Cathy West	French	0900	0920	0922	0945	Initial Assessment
Jenny Huang	Taiwanese	0930	0950	0950	1015	Other
Vickie Sears	Hmong	1000	1025	1026	1110	Discharge Instruction
Mariza Hardin	Hmong	1030	1125	1135	1200	Initial Assessment & Discharge Instruction
John Doe	Arabic	1045	1210	1220	1245	Initial Assessment & Discharge Instruction
Mary Jannie	Spanish	1100	1330	1420	1425	Discharge Instruction
Lisa Flores	Spanish	1330	1445	1450	1510	Initial Assessment
Dana You	ASL	1400	1520	1522	1538	Discharge Instruction
Sydney West	Spanish	1530	1552	1558	1615	Other
Cathy West	French	2200	2230	2235	2255	Discharge Instruction

† Write the time an interpreter was requested for an unscheduled visit or Write the time the patient arrived for a scheduled visit or admission

Glossary

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.

American Sign Language (ASL): manual language with its own syntax and grammar, used primarily by people who are deaf. [NIDCD-NIH]

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

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

Clinical encounters: interpreter encounters with patients and providers who assess, diagnose, and treat patients. Examples include: clinical assessment, discharge instructions, care plan management, informed consent discussions, discharge planning and any other process where physicians, nurses, pharmacists, social workers, registered dieticians, and other licensed clinical professionals are involved with the provision of care to LEP patients. [Adapted from ASTM E13840-02a]

Contract and/or agency interpreter: individuals employed by an entity separate and independent of the hospital where they are interpreting.

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]

Denominator: the lower part of a fraction used to calculate a rate, proportion, or ratio. Also the population for a rate-based measure. [CMS]

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

Encounter end time: encounter end time is when the provider and interpreter complete a post-session discussion (without the patient) immediately following the clinical encounter; if there is no post session, the encounter end time is the time when the interpreter stops interpretation for patient and/or providers and hospital workers/employees.

Encounter start time: encounter start time is when the provider and interpreter begin a pre-session discussion (without the patient) immediately prior to the clinical encounter; if there is no pre-session, the encounter start time is the time when the interpreter begins interpretation for patient and/or providers and hospital workers/employees.

Exclusion: detailed information describing the populations that should not be included in the measure. [CMS]

Hospital telephone interpreting: telephone interpreting method operated by the hospital

Hospital video interpreting: video interpreting method operated by the hospital

Inclusion: detailed information describing the population(s) or event(s) that the indicator intends to measure. [CMS]

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

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

Interpreter encounter: a meeting or period of time devoted to the delivery of interpretation for a patient who is communicating with hospital staff or providers in health care settings. This includes on-site and remote modes of interpreting. The encounters can be scheduled or unscheduled. One or more providers may be involved in the encounter. The family may or may not be involved in the encounter. Some encounters may involve the provider(s) and family only as in family meetings, pediatric cases, or when the patient's physical or mental condition renders them unable to participate. [NCIHC and CHIA]

Interpreting: the process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, while taking the cultural and social context into account. The purpose of interpreting is to enable communication between two or more individuals who do not speak each other's languages. [NCIHC, CHIA, CE and ASTM F2089]

Limited English-Proficient (LEP): ''Limited English-Proficient'' or ''(LEP)'' means a limited ability or inability to speak, read, write, or understand the English language at a level that permits the person to interact effectively with health care providers or social service agencies. [CHIA and CE]

Minutes worked: actual minutes worked, not budgeted or scheduled hours. The total amount of time, in minutes, interpreters spend at work.

Mode of interpreting: the method used to deliver interpretation services such as on-site, telephone, video or other remote simultaneous methods

Non-clinical encounter: interpreter encounters with patients and/or non-clinical personnel. Examples include: billing and finance, tutoring hospitalized children, way finding, arranging transportation and any process where non-clinical personnel are involved in the encounter.

Numerator: the upper portion of a fraction used to calculate a rate, proportion, or ratio. [CMS]

On-site interpreting: interpreting done by an interpreter who is directly in the presence of the speakers. Also called *face-to-face interpreting*. [NCIHC]

Outside vendor telephone interpreting: telephone interpreting operated by an entity separate and independent of the hospital.

Outside vendor video interpreting: video interpreting operated by an entity separate and independent of the hospital.

Patient: individuals, including accompanying family members, guardians, or companions, seeking physical or mental health care services, or other health-related services. [CHIA]

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

Preferred written language for health care information: the preferred language that is stated by the patient for reading written health care information.

Process Measure: a measure which focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome. [CMS]

Qualified language services providers: on-site and remote interpreters who have met the organizations training and assessment requirements to provide interpreter services to patients. Or bilingual providers or staff who have been assessed for language proficiency and met the organizations requirements for providing services and clinical care in a language other than English.

Remote interpreting: interpreting provided by an interpreter who is not in the presence of the speakers, e.g., interpreting via telephone or videoconferencing or TTY/TDD relay. [NCIHC and CHIA]

Scheduled interpreter encounter: an encounter for which a predetermined time was set for the interpreter to provide services.

Screening for preferred spoken language for health care: the practice of asking for and documenting a patient's language preference for speaking during health care encounters.

Screening for preferred written language for health care information: the practice of asking for and documenting a patient's language preference for reading written health care information.

Stratified: a form of risk adjustment which involves classifying data into subgroups based on one or more characteristics, variables, or other categories. [CMS]

Telephone interpreting: interpreting carried out remotely, with the interpreter connected by telephone to the provider(s) and patient(s).

Time interpreter arrived: the time when an interpreter reaches the location where interpretation will occur or the time when a remote interpreter is connected.

Time interpreter requested: the time when a provider, patient, clinic, or other coordinator requests an interpreter for an encounter for unscheduled encounters. The scheduled time of the interpreter encounter for scheduled interpreter encounters.

Translation: the conversion of a written text into a corresponding written text in a different language. [NCIHC]

Translator: a person who converts written texts from one language into a text in a second language with an equivalent meaning, especially one who does so professionally. [NCIHC and CE]

TTY/TDD: describes relay, a service enabling telephone communication between TTY/TDD customers (who are usually deaf or hard of hearing) and hearing people. [NCIHC]

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]

Unscheduled interpreter encounter: an encounter for which no predetermined time was set for the interpreter to provide services.

Video interpreting: interpreting carried out remotely that enables an interpreter in a remote location to both see and hear the provider(s) and patient(s) for which he/she is interpreting via a TV monitor. [NCIHC]

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

Citations:

ASTM E13840-02a: Subcommittee E31.19 of American Society of Testing and Materials. Standard guide for content and structure of the electronic health record (EHR). (Document E1384-02a). Conshohocken, PA.: American Society for Testing and Materials, 2003.

ASTM F0289: Subcommittee F15.34 of American Society of Testing and Materials. Standard Guide for Quality Language Interpretation Services (document F2089). Conshohocken, PA.: American Society for Testing and Materials, 2000.

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

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

CMS: Centers for Medicare & Medicaid Services and the Joint Commission. Specifications manual for national hospital inpatient quality measures discharges 10-01-09 (4Q09) through 03-31-10 (1A10). Version 3.0.

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.

Landrum and Weinrich 2006: Landrum, L., Weinrich, S. Readmission data for outcomes measurement: Identifying and strengthening the empirical base. *Q Manage Health Care* 2006: 15(2): 83–95

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

NIDCD-NIH: National Institute on Deafness and Other Communication Disorders-National Institute for Health: http://www.nidcd.nih.gov/health/hearing/asl.asp

References

Introduction and Background:

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).

L1A: Screening for preferred spoken language

Selected Literature:

Collecting race, ethnicity, and primary language data: Tools to improve quality of care and reduce health care disparities. The Health Research & Education Trust. 2005.

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

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.

Hasnain-Wynia, R., Pierce, D., Pittman, M. Who, when, and how: The current state of race, ethnicity, and primary language data collection in hospitals. The Commonwealth Fund. May 2004.

Hakimzadeh S, Cohn D. English usage among Hispanics in the United States. Pew Hispanic Center, The Henry J. Kaiser Family Foundation. 2007.

Nailon, R.E. The assessment and documentation of language and communication needs in healthcare systems: Current practices and future directions for coordinating safe, patient-centered care. *Nurs Outlook* 2007; 55: 311-317.

Pew Hispanic Center. Bilingualism (Survey brief). The Henry J. Kaiser Foundation. March 2004.

Regenstein, M, Sickler, D. Race, ethnicity, and language of patients: Hospital practices regarding collection of information to address disparities in health care. National Public Health and Hospital Institute. January 2006.

Regenstein M, Mead H, Muessig KE, Huang J. Challenges in language services: Identifying and responding to patients' needs. *J Immigrant Minority Health*. Published online only. June 2008.

L1B: Screening for Preferred Written Language

Selected Literature:

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

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.

Hakimzadeh S, Cohn D. English usage among Hispanics in the United States. Pew Hispanic Center, The Henry J. Kaiser Family Foundation. 2007.

Pew Hispanic Center. Bilingualism (Survey brief). The Henry J. Kaiser Foundation. March 2004.

L2: Patients receiving language services supported by qualified language service providers

Selected Literature:

Betancourt, J. R., Jacobs, E. A. Language barriers to informed consent and confidentiality: the impact on women's health. *J. Am. Med. Womens Assoc.* 2000; 55: 294-295.

Diamond, L.C., Schenker, Y., Curry, L., Bradley, E., Fernandez, A. Getting by: Underuse of interpreters by resident physicians. *J Gen Intern Med*. 2009; 24(2): 256-62.

Elderkin-Thompson V, Silver RC, Waitzkin H. When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting. *Soc Sci Med.* 2001; 52:1343–1358.

Ferguson, W. Un Poquito *Health Affairs.* November/December 2008; 27(6): 1695-1700.

Flores, G. Language barriers to health care in the United States. *NEJM*. July 20, 2006; 355:229-231

Flores, G., Laws MD, Mayo SJ et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. 2003; 116: 6-14.

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

Guidance to federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons. *Federal Register*. June 8, 2002; 76(117): 41455-41472.

Jacobs, E., Lauderdale, D., Meltzer, D., Shorey, J., Levinson, W., Thistead, R. Impact of interpreter services on delivery of health care to limited-English-proficient patients. *J Gen Intern Med*. 2001; 16(7): 468–474.

Schenker, Y., Lo, B., Ettinger, K.M., Fernandez, A. Navigating language barriers under difficult circumstances. *Ann Intern Med.* 2008; 264-269.

Schyve PM. Language differences as a barrier to quality and safety in health care: the Joint Commission perspective. *J Gen Intern Med.* 2007;22 Suppl 2:360-1.

L3: Patient wait time to receive interpreter services
L4: Time spent interpreting
L5: Interpreter wait time to deliver interpreter services

Selected Literature:

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

Regenstein M, Huang J, West C, Trott J, Stegun M. Hospital language services: quality improvement and performance measures. Advances in patient safety: new directions and alternative approaches. Vol. 1-4. Rockville (MD): Agency for Healthcare Research and Quality; 2008 Jul. (AHRQ publication; no. 08-0034)

Additional Selected Literature:

Andrulis D, Goodman N, Pryor N. What a difference an interpreter can make: health care experiences of uninsured with limited English proficiency. The Access Project; 2003 Apr.

Cheng EM, Chen A, Cunningham W. Primary language and receipt of recommended health care among Hispanics in the United States. J Gen Intern Med 2007 Nov;22 Suppl 2:283-8.

David RA, Rhee M. 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):393-7.

Flores G. Language barriers to health care in the United States. N Engl J Med 2006 Jul 20;355(3):229-31.

Hampers LC, Cha S, Gutglass DJ, Binns HJ, Krug SE. Language barriers and resource utilization in a pediatric emergency department. Pediatrics 1999 Jun;103(6 Pt 1):1253-6.

Hampers LC, McNulty JE. Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization. Arch Pediatr Adolesc Med 2002 Nov;156(11):1108-13.

Hasnain-Wynia RJ, Yonek R, Pierce D, Kang GC. Hospital language services for patients with limited English proficiency: results from a national survey. The Commonwealth Fund; 2006 Oct.

Jacobs EA, Shepard DS, Suaya JA, Stone EL. Overcoming language barriers in health care: costs and benefits of interpreter services. Am J Public Health 2004 May;94(5):866-9.

Ku L. How race/ethnicity, immigration status and language affect health insurance coverage, access to care and quality of care among the low-income population. The Henry J. Kaiser Family Foundation; 2003 Aug.

Ku L, Flores G. Pay now or pay later: providing interpreter services in health care. Health Aff (Millwood) 2005 Mar-Apr;24(2):435-44.

Ngo-Metzger Q, Sorkin DH, Phillips RS, Greenfield S, Massagli MP, Clarridge B, Kaplan SH. Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use. J Gen Intern Med 2007 Nov;22 Suppl 2:324-30.

Office of Minority Health and Health Disparities. Eliminating racial and ethnic disparities.

U.S. Bureau of the Census. American Community Survey: language spoken at home (table S1601). 2005.

Woloshin S, Schwartz LM, Katz SJ, Welch HG. Is language a barrier to the use of preventive services. J Gen Intern Med 1997 Aug;12(8):472-7.

Overview of Measure Information Form[1]

Measure Information Form Introduction:

Measure Set*:* The specific measure set to which an individual measure belongs (e.g., acute myocardial infarction, pneumonia).

Performance Measure ID: A unique alpha-numeric identifier assigned to a measure. Information associated with a measure is identified by this unique alpha-numeric number.

Performance Measure Name*:* A brief title that uniquely identifies the measure.

Description*:* A brief explanation of the measure's focus, such as the activity or the area on which the measure centers attention (e.g., pain management for terminally ill patients)

Domain of Quality*:* Identifies the IOM Domain of Quality assigned to a measure.

Rationale*:* The reason for performing a specified process to improve the quality of care outcome. This may include specific literature references, evidence based information, expert consensus, etc.

Type of Measure*:* Indicates whether the measure is used to examine a process or an outcome over time:

- *Process*: A measure used to assess a goal directed, interrelated series of actions, events, mechanisms, or steps, such as measure of performance that describes what is done to, for, or by patients, as in performance of a procedure.
- *Outcome*: A measure that indicates the result of performance (or non-performance) of a function(s) or process(es).

Improvement Noted As*:* Describes how improvement would be indicated by the measure:

- An increase in the rate/score/number of occurrences (for example, immunizations)
- A decrease in the rate/score/number of occurrences (for example, surgical site infections)
- Either an increase or a decrease in the rate/score/number of occurrences, depending upon the context of the measure (for example, utilization).

Numerator Statement*:* Represents the portion of the denominator that satisfies the conditions of the performance measure.

> Note: If the measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statement are completed. If a performance measure does not have both a numerator and a denominator, then a Continuous Variable Statement is completed.
>
> *Included Population in Numerator:* Specific information describing the population(s) comprising the numerator, not contained in the numerator statement, or not applicable.

[1] Modified from Centers for Medicare & Medicaid Services and the Joint Commission. Specifications Manual for National Hospital Inpatient Quality Measures Discharges 10-01-09 (4Q09) through 03-31-10 (1A10). Appendix e, Version 3.0.

Excluded Population in Numerator: Specific information describing the population(s) that should not be included in the numerator, or none

Data Elements: Those data elements necessary or required to determine (or establish) the numerator.

Denominator Statement: Represents the population evaluated by the performance measure.

Note: If measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statement are completed. If a performance measure does not have both a numerator and a denominator, then a Continuous Variable Statement is completed.

Included Population in Denominator: Specific information describing the population(s) comprising the denominator, not contained in the denominator statement or not applicable

Excluded Population in Denominator: Specific information describing the population(s) that should not be included in the denominator, or none

Data Elements: Those data elements required to determine (or establish) the denominator.

Risk Adjustment: Indicates whether a measure is subject to the statistical process for reducing, removing, or clarifying the influences of confounding factors to allow more useful comparisons.

Data Collection Approach: Recommended timing for when data should be collected for a measure. Data collection approaches include retrospective, concurrent or prospective data collection. *Retrospective* data collection involves collecting data for events that have already occurred. *Concurrent* data collection is the process of gathering data on how a process works or is working while a patient is in active treatment. *Prospective* data collection is data collection in anticipation of an event or occurrence.

Data Accuracy/Data Completeness: Recommendations to reduce identifiable data errors, to the extent possible.

Measure Analysis Suggestions: Recommendations to assist in the process of interpreting data and drawing valid conclusions.

Sampling: Indicates whether or not a measure can be sampled. Sampling is a process of selecting a representative part of the population in order to estimate the hospital's performance, without collecting data for its entire population.

Age Groups: Indicates the age group to which a measure applies.

Data Reported As: Indicates how data will be reported for a measure.

- Aggregate rate generated from count data reported as a *proportion* (for example, rate-based measures which report summary data generated from the number of Cesarean sections as a proportion of deliveries)
- Aggregate rate generated from count data reported as a *ratio* (e.g., bloodstream infection per 1,000 line days).

- Aggregate measures of *central tendency* (e.g., continuous variables which report means and medians such as length of stay).

Selected References: Specific literature references that are used to support the importance of the performance measure.

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