

CONTENTS

WEB ARTICLES

W3-2 **Quality and Safety of Hospital Care for Children from Spanish-Speaking Families with Limited English Proficiency**

Christina Bethell, Lisa Simpson, Debra Read, Elisa J. Sobo, Judi Vitucci, Brooke Latzke, Susan Hedges, Paul S. Kurtin

The issue of improvement in communication among patients and healthcare professionals is a priority on today's national healthcare quality agenda. This article discusses a study aimed at reducing communication-related, negative hospital quality and safety events for children from Spanish-speaking, limited English proficient (LEP) families. Twelve focus groups were conducted with parents, providers, and hospital quality improvement (QI) professionals. A survey for Spanish-speaking LEP parents was developed and evaluated for its perceived value for assessing communication-related aspects of quality and safety of hospital care. Parents, providers, hospital staff, and QI professionals perceived that language and cultural differences have a pervasive and often negative effect on the quality and safety of hospital care for children that is only partly related to the availability of language interpretation services. Both common and divergent perspectives regarding improvement priorities and the value placed on the survey topics were found in the responses of parents, healthcare providers, and QI professionals. Findings revealed substantial barriers to measuring or addressing problems with communication. Additional challenges include evaluating how these problems affect quality and safety of care and understanding how differences in language and culture have a unique impact on communication, quality, and safety.

W3-17 **q&a: Cheryl Knapp and Jane Janssen on the Baldrige Process at Bronson Methodist Hospital**

Joann Genovich-Richards

The Malcolm Baldrige National Quality Award is the nation's highest presidential honor for quality and organizational performance excellence, and in 2005 Bronson Methodist Hospital (BMH), Kalamazoo, MI, was the only healthcare recipient of the award. Bronson Healthcare Group's Cheryl Knapp and Jane Janssen spoke to *JHQ* about BMH's review process for the Baldrige award.

W3-19 **Conference Brief Report: Update on the National Health Policy Conference**

Jacqueline F. Byers

The National Health Policy Conference, sponsored by AcademyHealth and Health Affairs, was held February 6-7, 2006 in Washington, DC. Prominent national leaders from public and private sectors came together to discuss and debate current health policy issues. The review briefly highlights implications for healthcare quality professionals and refers readers to Web resources including Web casts of the presentations, Microsoft PowerPoint presentations and handouts from the speakers, and a conference summary.

DEPARTMENTS

W3-20 **Media Reviews**

W3-23 **Quality NETWORK**

W3-25 **Quality Products and Resources**



Quality and Safety of Hospital Care for Children from Spanish-Speaking Families with Limited English Proficiency

Christina Bethell, Lisa Simpson, Debra Read, Elisa J. Sobo, Judi Vitucci, Brooke Latzke, Susan Hedges, Paul S. Kurtin

Improving communication among patients and healthcare professionals is high on the national healthcare quality agenda. The Agency for Healthcare Research and Quality's (AHRQ) *20 Patient Tips to Help Prevent Medical Errors in Children* largely focuses on encouraging parents to be proactive, persistent, and effective in asking questions and ensuring that a full exchange of necessary information occurs (AHRQ, 2002). Parents and patients need sophisticated communication skills to employ these tips, which may be even less likely to be implemented if parents do not speak English or when assertive communication with professionals is not customary. The U.S. Department of Health and Human Services (DHHS) Culturally and Linguistically Appropriate Services (CLAS) standards and the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) culturally and linguistically appropriate care standards also focus on improving communication skills among patients, physicians, nurses, and other healthcare professionals as a key component of ensuring safe and high-quality care (U.S. DHHS, 2001; JCAHO, 2005a). Unlike the AHRQ tips, these standards assign responsibility for good communication to healthcare organizations and providers, pointing them to requirements in Title VI of the Civil Rights Act of 1964 to provide meaningful language access to programs, services, and activities for limited English proficient (LEP) persons.

Although a recent JCAHO report (2004) identified communication among healthcare professionals as the leading root cause of perinatal death and permanent disability in newborns (it was the cause in 72% of cases), few studies have focused explicitly on the association of communication between patients and healthcare professionals and the quality and safety of hospital care for children. Studies

Abstract: The issue of improvement in communication among patients and healthcare professionals is a priority on today's national healthcare quality agenda. This article discusses a study aimed at reducing communication-related, negative hospital quality and safety events for children from Spanish-speaking, limited English proficient (LEP) families. Twelve focus groups were conducted with parents, providers, and hospital quality improvement (QI) professionals. A survey for Spanish-speaking LEP parents was developed and evaluated for its perceived value for assessing communication-related aspects of quality and safety of hospital care. Parents, providers, hospital staff, and QI professionals perceived that language and cultural differences have a pervasive and often negative effect on the quality and safety of hospital care for children that is only partly related to the availability of language interpretation services. Both common and divergent perspectives regarding improvement priorities and the value placed on the survey topics were found in the responses of parents, healthcare providers, and QI professionals. Findings revealed substantial barriers to measuring or addressing problems with communication. Additional challenges include evaluating how these problems affect quality and safety of care and understanding how differences in language and culture have a unique impact on communication, quality, and safety.

on adult chronic disease care have documented the correlation between communication and timely and accurate diagnosis, patients' understanding of and adherence to medical regimens, and the receipt of effective care necessary to achieving good outcomes (Center for the Advancement of Health, 1999; DiMatteo, 1994; VonKorff, 1997; Wagner, 1998). There is little reason to believe that these same associations between communication and quality and safety of care do not exist in healthcare for children.

Key Words

children's healthcare
English proficiency
hospital quality

Journal for Healthcare Quality
Web Exclusive
Vol. 28, No. 3, pp. W3-2-W3-16
www.nahq.org/journal

© 2006 National Association for
Healthcare Quality

Some studies have documented the importance of ensuring high-quality language interpretation services to prevent medical errors (Flores, 2003; Ku, 2005). Resolution of communication and quality issues requires more than language interpretation services. A recent study by Cohen et al. (2005) found that Spanish-speaking hospitalized children whose parents were assigned an interpreter still had a two-fold increased risk for serious medical events compared with children whose parents did not need an interpreter. On the basis of these and related studies, we expect that communication will increasingly become a focus of hospital quality improvement (QI) or safety efforts. This study was designed to contribute knowledge and tools needed for such efforts specifically in regard to children from Spanish-speaking LEP families. This was an exploratory and qualitative study as well as a survey development study. Research questions addressed included the following:

1. What are the perspectives of parents, providers, hospital staff, and QI professionals regarding how language and related cultural differences between healthcare providers and families affect communication and, in turn, the quality or safety of hospital care for children?
2. What priorities and strategies for improving quality- and safety-related communication problems between providers and Spanish-speaking LEP families do parents, providers, and QI professionals recommend?
3. Is a parent-report survey tool valuable in assisting hospitals in the assessment of the nature and scope of potential communication-related threats to quality and safety of care for children from Spanish-speaking LEP families?

This study was conducted at children's hospital sites in south Florida and southern California. Both areas have a relatively high percentage of Spanish-speaking immigrant populations, making sampling more feasible for the parent focus groups and ensuring the salience of the study topic to participating hospitals.

Methods

A qualitative research method employing standardized focus group questions and exercises was used to explore and compare

perspectives among parents, providers, and QI professionals. No standardized survey tools were available to obtain quantitative data specific to the study questions so that comparisons across study populations could be made. Nor did the study funding provide for a large, sample-survey-based study design. In addition, direct involvement of parents, providers, and QI professionals was essential because medical charts and administrative data do not include the information that was the subject of this study—communication as related to quality and safety of care.

Twelve focus groups were conducted with 72 individuals in south Florida and southern California using standardized participant recruitment and focus group discussion guides and facilitation methods. Six focus groups were conducted in each geographic location. Five focus groups of parents were conducted with Spanish-speaking parents confirmed as having limited English proficiency and a child 0–17 years of age who had been hospitalized within the last 6 months at one of three children's hospital study sites ($n = 25$). Focus groups of providers were conducted with physicians, nurses, and other hospital staff who come in direct contact with families and children from Spanish-speaking LEP families in hospital settings ($n = 35$). The final two focus groups were conducted with QI professionals ($n = 12$). The parent and provider focus groups followed a panel design in which participants in an initial focus group returned for a second focus group approximately 1 month later. Approximately one half of Round 1 parent focus group participants ($n = 12$) and two thirds of Round 1 provider focus group participants ($n = 21$) also participated in the Round 2 focus groups. All materials and protocols were reviewed and approved by the human subjects review committees in each of the four participating institutions, and all participants provided informed written consent prior to the initiation of focus group discussion.

For purposes of this study, *LEP* was defined as follows: "individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be limited English proficient, or 'LEP,' and may be eligible to receive language assistance with respect to a particular type of service, benefit, or encounter" (U.S. DHHS, 2003, n.p.).

Focus Group Recruitment Process

Only Spanish-speaking LEP parents or guardians of one or more children who were 0–17 years of age and who had been hospital patients overnight or longer during a 6-month period were eligible for the study. In order to determine their LEP status, potential participants were asked several questions from the Pew Hispanic Center/Kaiser Family Foundation 2002 *National Survey of Latinos*:

1. What language do you usually speak at home? Is it:
 - A. Only or mostly Spanish
 - B. Spanish and English about equally
 - C. Only or mostly English?
2. Would you say that you can carry on a conversation in English, both understanding and speaking,
 - A. Very well
 - B. Pretty well
 - C. Just a little
 - D. Not at all?

If parents answered A to question 1 and B or C to question 2, they were eligible to participate in the focus groups.

Participants in the parent focus group were recruited from a pool of candidates using an introductory letter and a follow-up telephone call where a standardized recruitment script and protocol were administered by a single Spanish-speaking recruiter. Candidates for recruitment were identified through one of four methods: (1) a manual review of acute care logs indicating the occurrence of a hospital-stay follow-up appointment for a child during a 6-month period; (2) a computer report including names of parents of children who had an overnight stay during a 6-month period and who were also of Hispanic ethnicity; (3) a manual review of the neonatal discharge dataset to identify those children with a Hispanic or Latino surname; or (4) follow-up calls with parents who reviewed a recruitment letter and completed a recruitment survey (research interest form) during their child's hospital stay indicating their willingness to receive a phone call about the focus groups. Parent focus group recruitment flyers were also posted in hospital corridors, community agencies, and cultural centers, and interested parties were directed to call a toll-free number for more information. Only parents living within a 1-hour drive from the focus group location were recruited.

The recruitment script described the purpose of the study and the inclusion criteria.

Parents who met the inclusion criteria were asked about their interest in and availability to participate in a focus group at one of the scheduled dates, times, and locations. Parents who were available to attend one of the planned focus groups received a more detailed description of the format (audio-taping, informed consent, and procedures for ensuring confidentiality). After this information was delivered, their interest in participating was reconfirmed, and their attendance was scheduled. Parents chose whether to receive a confirmation letter or telephone call. Both the confirmation letter and reminder call included opt-out opportunities and a toll-free number to call if the parent was unable to participate or decided not to participate. Parents were provided a \$50 gift for their participation.

The majority of participants in the parent focus group were under 35 years of age and were mothers of children under 4 years of age. The majority of child hospitalizations were for acute conditions such as gastrointestinal problems, kidney infection, fever, respiratory problems, and complications as a result of surgery. Some were hospitalized for congenital or birth-related problems or chronic health problems such as diabetes or epilepsy. Because of Health Insurance Portability and Accountability Act requirements, information on reasons for hospitalization was obtained only from parents who shared that information with the focus group facilitator when they introduced themselves or in the course of the group discussion.

Participants in the focus groups for health-care providers, hospital staff, and QI professionals were recruited using four methods: (1) recruitment flyers posted in the participating hospital common areas; (2) e-mails to pediatric providers and members of the local healthcare quality association; (3) telephone calls to hospital employees eligible to participate, and (4) a fax-back interest form mailed to local pediatric providers. The recruitment flyer directed interested hospital staff and providers to call a toll-free number staffed by a hospital employee. A standardized recruitment script was administered to interested staff and providers by telephone to identify eligible participants. The script described the purpose of the study. All interested candidates were recruited. Both the confirmation letter and reminder call included opt-out opportunities and a toll-free number

to call if the person was unable to or decided not to participate. Healthcare providers were given \$100 for each focus group they attended. Hospital QI professionals were not provided with a financial gift for participation.

At the conclusion of both the parent and the provider Round 1 focus groups, attendees were invited to a follow-up focus group. All original attendees were contacted to re-invite them and confirm their attendance. Attendees received a reminder 2 days prior to the follow-up focus group.

Focus Group Facilitation and Exercises

An experienced bilingual, bicultural Spanish-speaking moderator facilitated each of the three parent focus groups in south Florida, and a different but similarly experienced bilingual, bicultural Spanish-speaking moderator facilitated each of the two southern California parent focus groups. The same study investigator conducted each of the provider and hospital QI professional focus groups in both study locations. The first round of parent and provider and QI professional focus groups included four phases: (1) introductions and an open-ended discussion on how participants define good- or poor-quality hospital care; (2) an adapted root cause analysis discussion about specific communication problems participants had witnessed or experienced; (3) a card-sort prioritization exercise to identify key problems perceived by participants (see **Table 1** for topics) and discussion of results; (4) specific input on how healthcare organizations should address the issues raised by the focus group participants. Provider, hospital staff, and QI professionals were informed that this study was focused on the experiences of Spanish-speaking LEP parents in particular and were asked to limit their thoughts and comments to this population.

Sixteen potential communication-related problems or issues were included in the card-sort exercise (Table 1). These were identified through a Delphi process among study investigators and six other experts in the field. First, project staff culled relevant literature and assembled a list of key communication-related problems that may affect healthcare quality and safety. The selected topics address issues throughout the hospital experience—from admission to discharge and follow-up. In addition, issues affecting patients' experience

of care, clinical effectiveness, efficiency, safety, equity, and timeliness of care were specified wherever possible. All study investigators reviewed the key problems and issues, as did the focus group facilitators and other experts in the field. Focus group participants were given the opportunity to identify any other issues they experienced that were not represented by one of the 16 potential problems in the card-sort exercise.

During the follow-up (Round 2) focus groups, the open-ended dialogue and card-sort exercises were repeated, and differences from Round 1 results were discussed. Parents commented on findings from Round 1 provider focus groups, and providers commented on Round 1 findings from parents. In the second round of focus groups, parents and providers reviewed a draft survey on hospital quality and safety and communication designed to collect information from LEP parents. Participants engaged in a mock money-spending exercise in which they were asked how they would spend \$100 across different survey measurement concepts. In addition, participants commented on whether and how the survey might be valuable and offered ideas for the most efficient, effective administration techniques and dissemination of findings. (**Table 2** lists the topics included in the draft survey for parents.)

Group discussions were taped, transcribed, and translated as needed. Because identifying the range of possible responses to the issues raised in the focus group protocol was the project goal, a content analysis and theme identification process was conducted using iterative reflection techniques (Strauss & Corbin, 1998). Extensive focus group reports were developed for each of the three groups. These reports are available upon request.

Results

Common and Distinctive Themes Identified by Parents, Providers, and Hospital QI Professionals

Twelve overarching themes emerged across the focus groups that are relevant to understanding parents', providers', and hospital QI professionals' views on whether and how language and cultural differences contribute to communication problems that, in turn, affect the quality and safety of hospital care for children of LEP families.

Table 1. Summary of Top Priorities for Improvement Selected by Focus Group Participants

Communication-Related Quality and Safety Problems Associated with Differences in Language and Culture	Parents (n = 25)	Provider/ Hospital Staff (n = 35)	QI Staff (n = 12)
Hospital staff and doctors do not respond quickly (card 16) <ul style="list-style-type: none"> Sometimes hospital staff and doctors seem hesitant to talk to a Spanish-speaking family because they do not understand their culture and language. 	Rank #1	Rank #9	Not selected as top priority by any participants
Family gives consent for procedures that they do not understand (card 5) <ul style="list-style-type: none"> A family might feel that they are required to agree to most tests and procedures. Even so, language differences may prevent them from understanding these tests and procedures. 	Rank #2	Rank #6	Rank #4
Information shared during the hospital admission process is incomplete or inaccurate (card 2) <ul style="list-style-type: none"> The doctors or hospital staff do not understand all of the child's health information because they may not speak the family's language or understand their culture. 	Rank #3	Rank #1	Rank #2
Leaving out important information (card 10) <ul style="list-style-type: none"> A family may share only big issues and not smaller issues because of language differences. Doctors and other hospital staff may do the same thing. The information that seems less important could be just as important. 	Rank #4	Rank #7	Rank #5
Families get conflicting information from different doctors (card 6) <ul style="list-style-type: none"> Sometimes a family can receive different opinions from different doctors. This makes it difficult for the family to understand their child's condition and how they can get the best care for their child. 	Rank #5	Rank #9	Rank #3
Lack of communication with child's community healthcare providers (card 13) <ul style="list-style-type: none"> Hospital doctors may not immediately communicate with the child's regular doctor. This makes it hard for the regular doctor to tell them what to do. 	Rank #5	Not selected as top priority by any participants	Rank #5
Medical tests and procedures are unnecessary or overly stressful (card 3) <ul style="list-style-type: none"> The child is given tests that the doctor felt were necessary, but had the doctor understood all the child's health information, he or she may not have felt these tests were necessary. 	Rank #5	Rank #6	Rank #5
Family is unsure about child's diagnosis and treatment plan (card 12) <ul style="list-style-type: none"> Sometimes a family may not understand their child's health problem and what they need to do after they leave the hospital. 	Rank #6	Rank #3	Rank #1
Families wait to ask for help until problems are more serious (card 9) <ul style="list-style-type: none"> A family may not seek treatment for medical problems until they are more serious in order to avoid difficulties with language and culture. 	Rank #6	Rank #5	Rank #2
Families hesitate to express concerns about their child's care (card 8) <ul style="list-style-type: none"> A family may hesitate to express concerns about their child's care or how their child is responding to treatment. 	Rank #7	Rank #2	Rank #4
Getting translation help is delayed or avoided (card 4) <ul style="list-style-type: none"> Sometimes a family will not ask for help translating because it is not offered or they worry translators will not do a good job. 	Rank #7	Not selected as top priority by any participants	Rank #5
Hospital admission is delayed or avoided (card 1) <ul style="list-style-type: none"> A family doesn't take their child to the hospital until the condition is more serious because they worry about culture and language differences. 	Rank #8	Rank #4	Rank #5

(continued)

Table 1. Summary of Top Priorities for Improvement Selected by Focus Group Participants (*continued*)

Communication-Related Quality and Safety Problems Associated with Differences in Language and Culture	Parents (n = 25)	Provider/ Hospital Staff (n = 35)	QI Staff (n = 12)
Undesirable or inappropriate food and entertainment choices (card 15) <ul style="list-style-type: none"> Sometimes the food and surroundings of a different language and culture make it difficult to feel comfortable during a hospital stay. 	Rank #8	Rank #9	Not selected as top priority by any participants
Family does not follow doctor recommendations (card 11) <ul style="list-style-type: none"> Sometimes a family is unable to follow their doctor’s advice because it conflicts with their values. 	Rank #9	Rank #8	Not selected as top priority by any participants
Family has difficulty trusting doctor recommendations (card 7) <ul style="list-style-type: none"> Sometimes a family can have trouble trusting their doctor’s advice because they are not sure the doctor understands their child’s condition or needs. 	Rank #9	Rank #9	Not selected as top priority by any participants
A family does not feel welcomed or comfortable (card 14) <ul style="list-style-type: none"> Sometimes a hospital’s visiting hours and hospital room make it hard for family members to be with their child when they want to. 	Not selected as top priority by any participants	Not selected as top priority by any participants	Not selected as top priority by any participants

Note. Problems are ranked according to the number of times participants selected the issue as priority 1 or 2.

Participants in the parent and provider focus groups identified four common themes:

- Telephone and lay interpreters are insufficient. Face-to-face language assistance services are inconsistently available, lack continuity, and are of varied and often poor quality.
- Communication-related problems in obtaining and transmitting clinically relevant information that affects quality and safety of care are common.
- Communication-related problems regarding the establishment of relationships and trust are extensive.
- Communication-related problems regarding the establishment of effective patient-provider partnerships in decision making and children’s healthcare provision are routine.

Participants in the provider and hospital QI professional groups identified four common themes:

- The unclear relationship between communication and quality and safety is a barrier to action.
- The lack of systems and views of quality related to health outcomes is a barrier to action.
- Communication problems are universal, and participants could not distinguish whether they are specific to or greater

for LEP children and families versus English-speaking children and families.

- Broader communitywide and social issues are at play that lead to quality problems for Spanish-speaking LEP children and families.

One theme was unique to parents:

- Dissatisfaction among hospital workers and racism contribute to and exacerbate communication, quality, and safety problems related to language and cultural differences.

Three themes were unique to QI professionals:

- Quality is mostly the same for all patients, regardless of their English proficiency.
- Lay interpreters are generally sufficient to address the needs of LEP patients.
- Measuring and improving communication with LEP families cannot be a QI priority until it is known exactly how to focus improvement efforts.

Figure 1 provides illustrative statements made by focus group participants for the key themes listed above. It is important to note that *no* themes were identified by all three groups.

Priority Problems for Improvement

Families, healthcare providers, and hospital QI professionals agree and disagree on high-priority issues for improvement in the area of communication, language, and culture.

Table 2. Draft Survey for Parents: Topic Areas, Sample Questions, and Average Amount Spent in Each Topic Area by Focus Group Participants

Topic Areas and Sample Questions	Providers (n = 32)	Hospital QI Professionals (n = 12)
<p>Getting and understanding discharge and follow-up instructions and getting help to implement these instructions</p> <ul style="list-style-type: none"> • Was interpreter available to translate explanations of medical tests and procedures? Whom did parents rely on most to help translate explanations? • Did parent get information in writing about what symptoms or health problems to look out for after discharge? • Did parent get information in writing about how to give any medicine to child at home? Was information to parents written in parent's language? Before discharge did anyone tell parent when and how to make an appointment for follow-up with child's regular doctor or nurse? 	\$28.48 (23 of 32 people spent money on this topic.)	\$24.09 (9 of 12 people spent money on this topic.)
<p>Getting and understanding information about child's medications</p> <ul style="list-style-type: none"> • Were new medicines given to child during hospital stay? • Was interpreter available to translate explanations of medicines and possible side effects? Did doctors, nurses, or hospital staff ask if child had allergies to medicines before giving child a new medicine? • Were parents asked about use of traditional methods of healing such as herbs? 	\$22.50 (20 people spent money on this topic.)	\$26.58 (12 people spent money on this topic.)
<p>Consenting to and understanding information about child's medical procedures</p> <ul style="list-style-type: none"> • Did parents provide consent prior to medical tests and procedures? • Was interpreter available to translate explanations of medical tests and procedures? Whom did parents rely on most to help translate explanations? • How well did parents understand explanations about medical tests and procedures? 	\$20.94 (18 people spent money on topic.)	\$18.74 (8 people spent money on this topic.)
<p>Overall need for and availability of interpreter services</p> <ul style="list-style-type: none"> • Was there a need for language assistance? • How often were nonfamily interpreters available? • How often did families experience delays in getting help with translation? • Did doctors, nurses, or other hospital staff do all they could to get translation help? 	\$19.36 (16 people spent money on this topic.)	\$14.30 (7 people spent money on this topic.)
<p>Getting clear and culturally sensitive help and information to understand child's health situation</p> <ul style="list-style-type: none"> • How often did families experience delays or problems getting help or information needed because of translation or language difficulties? How often did families feel unclear or unsure about child's situation because of interpreter or language difficulties? • How much respect and understanding did doctors, nurses, and other hospital staff show toward family's values and customs? 	\$18.91 (14 people spent money on this topic.)	\$16.43 (7 people spent money on this topic.)
<p>Availability of written forms in Spanish</p> <ul style="list-style-type: none"> • Were forms written in parent's language? • Was the content and purpose of forms explained to parent before signing? 	\$13.50 (10 people spent money on this topic.)	\$12.00 (5 people spent money on this topic.)
<p>Ease of obtaining interpreter support during hospital admission</p> <ul style="list-style-type: none"> • Was an interpreter available? • Whom did parents rely on most to help translate? 	\$11.36 (11 people spent money on this topic.)	\$12.26 (11 people spent money on this topic.)

Note. Average is calculated according to the number of participants spending any money in the topic area.

Figure 1. Overarching Themes: Examples of Participants' Comments

Telephone and lay interpreters are insufficient. Face-to-face language assistance services are inconsistently available, lack continuity, and are of varied and often poor quality.

- "You call someone, and they say 'get a [person from] cleaning staff—they speak Spanish.' So you have an environmental person come over here and speak Spanish to them." (provider)
- "For a 14-year-old to be translating to the mother that her [newborn] sister isn't doing too well is extremely traumatic." (parent)
- "It [phone interpretation] is very impersonal, especially when you are from another culture, and you are not used to that; it doesn't do the trick. It only works for intake, coming into the floor, where I need some information—what is your age? etc." (provider)
- "My personal experience with asthma [is] there is a lot of equipment. I can't use the phone. I need a person to demonstrate, to physically be there." (provider)

Communication-related problems in obtaining and transmitting clinically relevant information that affects quality and safety of care are common.

- "I treat with very significant medicine, and I have to explain how difficult and toxic those medicines are. Very often I have trouble convincing [parents] that's a better way to go than letting the disease just march on. So communication is huge, and trust is huge, in what I do." (provider)
- "The mom or dad can't say to you, 'they did this down in the ED last night, and he started having seizure-like activities.' That's a huge point—that the patient is having seizure activities. That the patient's family is not able to communicate that to me is a quality and a safety issue." (provider)
- "I'm sure we don't know if we have gotten the complete information from patients and families, and we do tests and procedures that may have already been done." (hospital QI professional)
- "If I would have explained all of my child's medical history, then maybe they would have not needed to do certain testing." (parent)
- "The nurse did not identify any needs. I [an interpreter] come 5 minutes later and identify five needs." (provider)
- "My daughter is sick and in the hospital for 40 days. I was not told how I should treat her, that I had to follow a certain treatment. [The telephone translation was not adequate.]" (parent)
- "I had to go back two times because [my daughter] got sicker. It was not the right treatment for what she had . . . maybe because of a doctor error or because they did not immediately give me a translator." (parent)
- "[If] the child is allergic to some type of medication and we won't know how to mention that he is allergic, then maybe they [the hospital staff] could give that child that medicine." (parent)
- "We had an expiration in the emergency center, and it was a Spanish-speaking family who said they were not listened to." (hospital QI professional)
- "I know the nurse noted all this stuff [vital signs], but 'as soon as she drank that, she threw it up'—I don't know that information. I just don't think that's the same level [of care provided] as for someone who can actually communicate with me." (provider)
- "There was a case of a child where the toes have been blue and [the child] actually almost [had] a toe lopped off because of a loss of circulation just because they were doing a discharge that was inadequate where pain control issues aren't communicated." (provider)

Communication-related problems regarding the establishment of effective patient-provider partnerships in decision making and children's healthcare provision are routine.

- "I think there is a different amount of time that is spent, by at least physicians—you see the patients whose language you are most comfortable with." (provider)
- "When a person does not speak English . . . the doctor says, 'Well, this one does not speak English. What am I doing here? I am wasting my time.' They [the doctors] take the easiest way out. They cut information. They do not help the person." (parent)
- "When you talk with them [providers and hospital staff], they only tell you the basics. I think they do not explain [details] to us because they feel we will not understand." (parent)
- "[With] asthma, you better go home and do the treatments, and if we can't talk to them, it doesn't happen. . . . We say 'take all of the antibiotics'—it says 2 weeks, so I take 2 weeks' worth. If I don't speak the language, then I can't impress upon you that the outcome [if all the antibiotics aren't taken] isn't good. So to have a process and a good outcome, you have to have a good shared communication." (hospital QI professional)

The unclear relationship between communication and quality and safety is a barrier to action.

- "I provide excellent care to my Hispanic patients. . . . There are some barriers, but it doesn't affect my level of care or recommendations for treatment." (provider)
- "I think the quality of patient care is excellent, but the quality of building relationships with someone that you can't communicate with, I think is a lot less." (provider)

Table 1 lists 16 potential communication-related problems that prior research suggests may arise because of differences in language and culture and that may also affect health-care quality and safety. The ranking assigned by focus group participants to each problem (according to how many selected a problem as one of their top two priorities for improvement in the card-sort exercise) is also shown.

Of these 16 potential communication-related problems identified by prior research, at least 25% of participants in at least one of the three groups identified the following 11 problems (via the card-sort activity) as being one of their top two priorities for improvement. (See Table 1 for more information.)

1. Hospital staff and doctors do not respond quickly to LEP families.
2. Families give consent for procedures and treatments that they do not understand.
3. Information shared during the hospital admission process is incomplete or inaccurate.
4. Families hesitate to express concerns about their child's treatment or response to treatment.
5. Families are unsure about their child's diagnosis and treatment plan.
6. In order to avoid language difficulties, families wait until problems are more serious before they ask for help.
7. Both families and providers leave out seemingly unimportant, but clinically relevant, information because of language differences.
8. Families receive conflicting information from different doctors and nurses and through different interpreters translating for those providers.
9. Hospital doctors do not contact the child's primary care provider to explain the child's hospitalization and treatment.
10. Medical tests and procedures are unnecessary or are overly stressful because of problems with language and cultural sensitivity.
11. Hospital admission is delayed or avoided because of worries associated with language and cultural differences.

Parents, providers, and hospital QI professionals varied in their top two priorities for improvement (Table 1). Overall, parents ranked "doctors do not respond quickly" as their highest priority for improvement, and

providers selected this as their lowest priority, even though providers openly acknowledged during the focus groups that they avoided LEP families and children or spent less time with them. Also notable is that providers and QI professionals were much more likely to identify problems related to how language and cultural differences may lead to parents' hesitancy to share information or concerns or to seek care for their child. Although these were acknowledged as issues for parents, fewer than one quarter of parent participants selected these as top priority problems.

Strategies for Improvement

Issues identified in the priority problems exercise summarized in the previous section provide insight into what participants describe as clinically relevant quality and safety problems affected by communication. The ideas for improvement shared by focus group participants also point to the potential root causes of communication-related threats to quality and safety associated with differences in language and culture. From the perspective of participants, a lack of attention to the ideas for improvement may perpetuate these problems.

Parents, providers, and QI professionals set forth 11 specific ideas for improvement. All three groups contributed these four ideas:

- Provide more medically trained interpreters through each phase of the hospital stay. Ensure continuity of interpreters for families and providers. Telephone translation is insufficient—it is impersonal, does not consider body language, and prevents demonstration of use of equipment and medication dosing.
- Develop a universal focus on improving communication skills.
- Be patient with families and encourage and help them to be more empowered and to speak up.
- Provide a checklist and information form so that parents can record their questions in preparation for the arrival of interpreters.

Parents and providers recommended four additional ideas for improvement:

- Require routine provider and staff training in cultural sensitivity.
- Let parents know when interpreters are expected to arrive.

- Increase Spanish-language signage and the availability of written materials in Spanish.
- Provide parents with trustworthy and knowledgeable support personnel.

Parents suggested two distinctive actions expected to address the quality- and safety-related communication problems identified through the focus group discussion:

- Identify language assistance needs early.
- Hire more nurses.

Figure 2 provides illustrative statements made by focus group participants for some of the ideas for improvement listed above.

Value of Surveying LEP Parents

Participants from each of the focus groups expressed the view that information derived from a Spanish-speaking LEP parent survey would be necessary and valuable to inform, shape, and track efforts to improve communication, quality, and safety of hospital care for children. Parents were not as familiar with the concept of a survey and expressed some doubt that survey findings would actually be used by hospital leaders to improve care for children. However, the parents were eager to have their views understood by hospital leaders and healthcare providers, and they found the draft survey topics (itemized in Table 2) relevant to the issues they raised during the focus group sessions.

Providers and QI professionals noted that currently no information regarding the communication-related quality and safety issues specific to Spanish-speaking LEP parents is collected in a standardized or routine way. Yet participants in both groups expressed questions and concerns about the logistics and use of this information by management, noting issues of sampling and administration and noting also the importance of comparing findings from LEP families with those of English-speaking families.

Table 2 summarizes how much value, on average, providers, hospital staff, and QI professionals placed on the seven topics included in the survey. Results show that the greatest value was placed on collecting information from Spanish-speaking LEP parents about “getting and understanding discharge and follow-up instructions and getting help to implement these instructions,” “getting and understanding information about child’s

prescription medications,” and “consenting to and understanding information about child’s medical procedures.” Participants’ least-valued topics related to “availability of written forms in Spanish” and “ease of obtaining interpreter support during hospital admission.” Providers and QI professionals demonstrated similarities in their ranking of the value of getting information from parents across the survey topics. Although QI professionals spent about the same amount as providers on “ease of obtaining interpreter support during hospital admission,” nearly all of these participants spent at least some money on this topical area, whereas only some providers did so.

Limitations

As is the case in nearly all focus group studies, input received by participants may not be representative of all members of a target population. In particular, we hypothesize that the selection bias in this study limited the participation of parents who are more disenfranchised from the healthcare system or whose lives are more hectic because of various socioeconomic and psychosocial stressors. In this way, results could underestimate the intensity and nature of problems that such vulnerable families may experience. In addition, findings may not be applicable to hospitals with very few Spanish-speaking LEP patients, because this study focused on sites with a relatively high proportion of such patients to ensure salience of study topic and feasibility of sampling for parent groups.

A second study limitation is the result of implementing an adapted root-cause-analysis questioning sequence. Here, rather than identifying underlying causes of one specific problem, the group context required that similar issues identified by several focus group participants be assessed using a series of questions to probe into perceived underlying causes and issues that could be acted on. This method yielded a wide range of input that allowed us to identify common problems and perceived underlying causes for each of the focus groups. The focus groups were more structured than usual and the discussion was directed to a large degree because we used the root cause approach, which possibly limited the nature of data elicited and limited the opportunity for unanticipated issues to arise through the participants’ discourse. To minimize this limitation,

Figure 2. Ideas for Improvement: Examples of Participants' Comments

Provide more medically trained interpreters through each phase of the hospital stay.

- "I took the training on how to be an interpreter . . . it is a lot different when an interpreter is professionally trained. It is totally different." (provider)
- "If a person doesn't have training in how to do medical translation, then how are they sure that the information they are giving the family is being understood and that the family is asking appropriate questions and is able to voice their concerns?" (hospital QI professional)
- "When you do get that translator, the tone is always rushed, because that poor person has 2 minutes. During your whole translation they are being consistently paged, getting up, and interrupting your interview or your assessment, which absolutely impacts your relationship with the patient, the information that is being [conveyed and received]—half the time you are repeating what you are trying to do. It's very chaotic." (provider)
- "I think if we have unit-specific translators that have a base knowledge of the issues that go on in our specific unit clinically, that's going to help. I've actually seen translators who come on the unit, and they've seen these patients before. Because he's built this relationship, it increases that level of trust. And I think we can get better outcomes from that relationship." (provider)

Be patient with families and encourage and help them to be more empowered and to speak up.

- "We have to give them some space for questions. We did this with our patients, and they rattle off 14 things they don't get." (provider)

Provide a checklist and form so that parents can record their questions in preparation for the arrival of interpreters.

- "When I am admitting them, I say, 'You know the child best. Please write down questions. Here's a piece of paper so you can do that.' I let them know that when we do get a translator, we want to be ready to talk." (provider)

Ensure that hospital managers are committed to addressing these issues and have a strategy for addressing them.

- "Administration needs to recognize that this is a problem, and they do not recognize that this is a problem because there are people all over the place that are . . . band-aiding the situation." (provider)
- "The data from the consumer is essential. I think that [the survey] gives you a very good picture. I don't think we get evaluated by the consumer the way we should in this hospital." (provider)
- "I would say do not assume because I don't get a safety report on it then it's not a problem, because obviously it is. And then measure and see what we can do to make a difference." (hospital QI professional)
- "The Spanish-speaking population is skewed to the pediatric population more so than the adult population, so the pediatric population sees the need more, but the pediatric population isn't that population that brings in the dough to the hospital." (provider)

Require routine provider and staff training in cultural sensitivity.

- "I think it's terror sometimes on the physicians' part and the nurses': 'How am I going to speak enough Spanish to get through on my own? Did they really understand what I'm saying? Am I hearing them correctly?' It's really frightening to be in that position." (provider)
- "I [a female doctor] will explain all the things with a translator to the mom and dad, but then the dad comes back out looking for the male physician to speak with." (provider)

Increase Spanish-language signage and the availability of written materials in Spanish and in English—especially discharge and prescription medication information.

- "That is very important (to have medication directions in Spanish) because at times we don't know—we forget, we are distracted or preoccupied, and we don't remember specifically how many it will be. And if we don't know how to read it, we don't know how to give it, and it is very difficult to be home with a medicine and not remember it. That is dangerous—we could give it wrong." (parent)
- "If they get the wrong medicine, if I [a translator] am not there to check out the right medicine, the patient will die. I have had cases like that." (provider)
- "While our computer in our retail pharmacy automatically translates the directions or what have you into Spanish, of course when the label comes out, I have no idea whether it's right or wrong [because he does not read Spanish]." (hospital QI professional)

Provide parents with trustworthy and knowledgeable support personnel.

- "There's one more strategy, and that is using parents, which we do in our clinic. We have a parent liaison. Spanish-speaking parents can act as coaches for each other." (provider)

Identify language assistance needs early.

- "It would be nice if we were notified ahead of time [that a patient or family was going to need a translator]." (provider)

participants were provided with several opportunities to identify issues not otherwise raised in the structured discussions and exercises.

Although dramatic differences in findings were not found between the southern California and south Florida populations, possible differences were not systematically explored. Regional differences in the viewpoints of patients, providers, and QI professionals have been shown to have a significant effect upon healthcare processes and outcomes (Payer, 1988). However, the study does elucidate difficulties for Spanish-speaking LEP families at the general level and introduces findings that promise to have broad national application.

Discussion

This study shows how language and cultural differences between patients and healthcare providers may affect communication and, in turn, lead to or exacerbate existing problems with the quality and safety of hospital care for children from Spanish-speaking LEP families. The common and distinctive perceptions obtained from parents, healthcare providers, hospital staff, and QI professionals enrich our understanding of the specific issues that arise in practice and help to lay the groundwork for formulating improvement strategies. The finding that providers and professionals understand that communication problems are universal and not limited to LEP children and families confirmed the findings of other studies (Sobo & Seid, 2003).

The ideas for improvement shared by focus group participants align with all but 2 of the 14 national CLAS standards for ensuring culturally and linguistically appropriate healthcare services. (The two national CLAS standards that did not align with input provided by focus group participants are (2) Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area, and (14) Healthcare organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities. In addition, the survey questions for parents identified in this study are relevant to assessing most of the issues set forth in the AHRQ's *20 Patient Tips to Help Prevent Medical Errors in Children*. More

information on the draft parent survey may be obtained from Christina Bethell and is available through a toolkit developed in this study.

If these findings can be generalized, fundamental barriers to implementing the many strategies for improvement set forth by focus group participants exist. In particular, we found a propensity for many providers and QI professionals to acknowledge a range of serious communication problems yet to dismiss the impact of these problems on quality and safety of care until further group discussion took place. This finding suggests the need to discuss further with healthcare providers and QI professionals how communication and the quality and safety of care can be linked. It is equally critical to move beyond what appears to be a non-outcomes-oriented definition of quality of care among providers (the view that quality is "doing your best in the moment" vs. "meeting patient needs and getting good outcomes"). Ironically, the common perspective of hospital professionals that communication, quality, and safety problems are not necessarily more prominent for LEP families than English-speaking families presents a barrier to action rather than a motivating perspective. The often-shared opinion that existing language assistance services that significantly rely on the telephone and lay interpreters rather than on medically trained, face-to-face interpreter services are sufficient presents a barrier as well.

Although a number of perspectives were shared by all participants, it is important to move beyond a qualitative assessment to a quantitative and standardized approach to measuring communication and quality and safety of care. In fact, our findings confirm that quantitative measurement is perceived as critical. Linking child-level data from something like the draft survey for parents used in this study with data on quality and medical errors collected in administrative or medical records was viewed favorably by parent, provider, and QI professional participants and may be a starting point for further defining in what areas, for whom, and how communication and healthcare quality and safety are related and may be addressed.

Our findings suggest that communication problems influence the timely, accurate, and effective exchange of clinically relevant information and the degree to which mutual trust, respect, and working partnerships with families are established. They also support the

conclusion that, their pervasiveness notwithstanding, quality- and safety-related problems with communication and patient-centered care are likely to be more of a problem for Spanish-speaking LEP families than for English-speaking families. Recently released findings from the National Survey of Children's Health (NSCH), which surveyed over 100,000 families regarding the health and healthcare their children receive, support this conclusion. NSCH data show that children from Hispanic families that speak Spanish at home are more likely to lack a personal doctor or nurse who knows their child and more commonly report poor communication with the healthcare provider(s) their child does see compared with children from non-Hispanic families that speak English as their primary language (68.5% versus 29.9%, $p < .001$) (Child and Adolescent Health Measurement Initiative, 2005).

Conclusions

In the present study, the input received from focus group participants confirmed findings from earlier studies that language and cultural differences have a pervasive and often negative effect on the perceived quality and safety of hospital care for children. They also suggest that substantial barriers to measuring or addressing problems with communication exist. Additional challenges lie in evaluating how these problems affect healthcare quality and safety and understanding how differences in language and culture have a special effect on communication, quality, and safety. Findings from this study lend support to the following seven conclusions:

1. *All aspects of quality can be affected.* Language and related cultural differences between LEP families and hospital providers and staff can present pervasive and often serious threats to the quality and safety of hospital care for children. Patients' experience of care, timeliness of care, effectiveness of care, efficiency, equity, and safety of healthcare—the key domains of quality—(Institute of Medicine, 2001) may all be affected by language and cultural differences.
2. *Multiple levels of change are involved.* Preventing and addressing communication problems requires involvement across the hospital and within the community. Strategies for improvement are required
3. *Divergent perspectives may limit progress.* Divergent perspectives among parents, providers, hospital staff, and QI professionals about the nature of the problem and who is responsible for addressing problems can make progress difficult. Efforts may be needed to create a shared understanding and shared accountability for reducing quality and safety problems associated with communication, language, and cultural differences.
4. *Measurement is important.* To understand and track improvements, more measurement of needs and problems may be required. In particular, parent and family input may be useful in identifying the nature and extent of communication problems that are associated with healthcare quality and safety.
5. *Parents are key partners in ensuring good communication and the quality and safety of care.* As outlined in the AHRQ 20 Patient Tips to Help Prevent Medical Errors in Children, parents and children play an important role in ensuring good communication and the quality and safety of hospital care for children. In many ways, hospital staff and providers count on parents to be empowered, ask questions, and be persistent. At the same time, little is done to encourage or support parents in this role, which the data suggest is often subverted by healthcare policies and practices. Linguistic and related cultural differences make this even more of a challenge for Spanish-speaking LEP parents.
6. *Communication problems are not limited to Spanish-speaking LEP patients.* Problems with communication and quality and safety of care experienced by Spanish-speaking LEP families likely reflect a more universal issue with the culture of medicine that works against a partnership-oriented and culturally sensitive model of healthcare (Sobo & Seid, 2003).
7. *Hospitals can take action now.* Although further research is needed to specify

at the level of the provider-patient relationship, within the care setting, across the organization at large, and within the community and policy environment that influences hospital priorities and resources.

effective interventions and improvement efforts, hospitals do not need to wait to address the problems of Spanish-speaking LEP families. Federal regulations (Title VI of the Civil Rights Act) and national standards (e.g., CLAS standards) require hospitals both to ensure meaningful language access and to compel hospitals to address the universal and specific communication problems LEP families experience that threaten the quality and safety of hospital care for children. JCAHO and other organizations are actively involved in projects to assist hospitals in this area (Hasnain-Wynia & Pierce; JCAHO, 2005b).

Moving from awareness of the issues and requirements for change to improvement will require continued research and efforts to translate this research into practice. In particular, research is needed to develop tools that hospitals can use to further document and demonstrate the link between communication and healthcare quality and safety, to assess current performance in this area, and to design and test strategies for improvement such as those set forth in the National Initiative for Children's Healthcare Quality's (NICHQ) report "Improving Cultural Competency in Children's Health Care" (NICHQ, 2005). The ideas for improvement identified in the field to date have implications spanning from the training and development of healthcare professionals to the education and empowerment of families and children to the design and application of clinical information systems. Hospitals willing to participate in the development, testing, and implementation of the needed tools and strategies for improvement are critical to ensuring that the many communication-related threats to the quality and safety of hospital care for children from Spanish-speaking LEP homes are minimized.

Acknowledgments

The authors would like to thank the Commonwealth Fund and the California Endowment for their support of this project and Glenn Flores for his consultation on project design and analysis. We also thank family focus group facilitators Milagros Abreu, MD, Leticia Reyes Gelhard, MA, and Lillilan Barreiro, who assisted in focus group recruitment and translation of materials and transcripts, as well as Alissa Green, who provided

excellent assistance in the final formatting and submission of this paper.

References

- Agency for Healthcare Research and Quality. (2002). *20 tips to help prevent medical errors in children*. AHRQ Publication No. 02-P034. [Electronic version]. Retrieved March 15, 2005, from www.ahrq.gov/consumer/20tipkid.htm.
- Center for the Advancement of Health. (1999). *Patients as effective collaborators in managing chronic conditions*. New York: Milbank Memorial Fund.
- Child and Adolescent Health Measurement Initiative. (2005). *Data resource center for child and adolescent health*. Retrieved March 15, 2005, from www.cshcnodata.org.
- Cohen, A. L., Rivara, F., Marcuse, E. K., McPhillips, H., & Davis, R. (2005). Are language barriers associated with serious medical events in hospitalized pediatric patients? *Pediatrics*, *116*(3), 575-579.
- DiMatteo, R. M. (1994). Enhancing patient adherence to medical recommendations. *Journal of the American Medical Association*, *271*(1), 79-83.
- Flores, G., Laws, M. B., Mayo, S. J., Zuckerman, B., Medina, L., Abreu, M., et al. (2003). Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*, *111*(1), 6-14.
- Florida Initiative for Children's Healthcare Quality, Child and Adolescent Health Measurement Initiative, All Children's Hospital. (2005). *Communication and culture: The common denominator in improving quality and safety of care for children. A toolkit for innovative health care leaders*. Retrieved March 15, 2005, from www.ohsdoernbecher.com/cahmi/spotlights/Toolkit_final.pdf.
- Hasnain-Wynia, R., & Pierce, D. (2005). *A toolkit for collecting race, ethnicity, and primary language information from patients*. Chicago: Health Research and Educational Trust.
- Institute of Medicine, Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A new health system for the 21st century* (J. M. Corrigan, M. S. Donaldson, L. T. Kohn, S. K. Maguire, & K. C. Pike, Eds.). Washington, DC: National Academies Press.
- Joint Commission on Accreditation of Healthcare Organizations. (2004). *Sentinel Event Alert*, Issue 30. [Electronic version]. Retrieved March 15, 2005, from www.jcaho.org/about+us/news+letters/sentinel+event+alert/sea_30.htm.
- Joint Commission on Accreditation of Healthcare Organizations. (2005a). *Requirements related to the provision of culturally and linguistically appropriate health care*. [Electronic version]. Retrieved August 31, 2005, from www.jcaho.org/about+us/hlc/hlc_jc_stds.pdf.
- Joint Commission on Accreditation of Healthcare Organizations. (2005b). *Hospitals, language and culture: A snapshot of the nation. Project update*. [Electronic version]. Retrieved August 31, 2005, from www.jcaho.org/about+us/hlc/home.htm.
- Ku, L., & Flores, G. (2005). Helping the millions of Americans with limited English proficiency can improve the quality of care and reduce the risk of medical errors. *Health Affairs*, *24*(2), 435-444.
- National Initiative for Children's Healthcare Quality. (2005). *Expanding perspectives: Improving cultural competency in children's health care*. [Electronic version]. Retrieved September 8, 2005, from www.nichq.org/NR/rdonlyres/5B534B7B-0C38-4ACD-8996-EBB0C4CB2245/0/CulturalCompetencyFINAL.pdf.
- Payer, L. (1988). *Medicine and culture: Varieties of treatment in the United States, England, West Germany, and France*. New York: Henry Holt and Company.

- Pew Hispanic Center/Kaiser Family Foundation. (2002). *2002 National survey of Latinos*. Kaiser Family Foundation Web site. [Electronic version]. Retrieved December 22, 2005, from www.kff.org/kaiserpolls/20021217a-index.cfm.
- Sobo, E. J. & Seid, M. (2003). Cultural issues in health services delivery: What kind of "competence" is needed? *Annals of Behavioral Science and Medical Education*, 9(2), 97-100.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- U.S. Department of Health and Human Services Office of Minority Health. (2001). Culturally and Linguistically Appropriate Services (CLAS). *Federal Register*, 65(247). [Electronic version]. Retrieved March 15, 2005, from www.omhrc.gov/clas/frclas2.htm.
- U.S. Department of Health and Human Services Office for Civil Rights. (2003). *Guidance to federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons*. U.S. Department of Health and Human Services Web site. [Electronic version]. Retrieved December 22, 2005, from www.hhs.gov/ocr/lep/revisedlep.html.
- Von Korff, M., Gruman, J., Schaefer, J., Curry, S. J., & Wagner, E. H. (1997). Collaborative management of chronic illness: Essential elements. *Annals of Internal Medicine*, 127(12), 1097-1102.
- Wagner, E. H. (1998). A population-based approach to diabetes management in a primary care setting: Early results and lessons learned. *Effective Clinical Practice*, 1(1), 12-22.

Authors' Biographies

Christina Bethell, PhD MBA MPH, is associate professor at the Oregon Health and Science University and the founding director of the Child and Adolescent Health Measurement Initiative, Portland, OR.

Lisa Simpson, MB MPH BCh FAAP, is the endowed chair in child health policy and director at All Children's

Hospital and the University of South Florida, Department of Pediatrics. She was formerly the deputy director at the Agency for Healthcare Research and Quality at the U.S. Department of Health and Human Services.

Debra Read, MPH, is a senior research associate with the Child and Adolescent Health Measurement Initiative, Portland, OR.

Elisa J. Sobo, PhD, is associate professor in the Department of Anthropology, San Diego State University, and associate clinical professor in the School of Medicine, University of California-San Diego.

Judi Vitucci, PhD ARNP, a nurse practitioner and medical anthropologist, is executive director of the Healthy Start Coalition of Pinellas, Inc., a nonprofit service agency focused on pregnant women and infants in Pinellas County, FL.

Brooke Latzke is a senior research assistant with the Child and Adolescent Health Measurement Initiative at Oregon Health and Science University, Portland, OR.

Susan Hedges, MPH CHES, is a research associate and adjunct faculty member at the Maternal and Child Health Initiative for the Institute for Public Health in the Graduate School of Public Health at San Diego State University, San Diego, CA.

Paul S. Kurtin, MD, is vice president for clinical innovations and director of the Center for Child Health Outcomes at Children's Hospital, San Diego, CA. He is also the founding medical director of the Child Health Accountability Initiative, a collaborative of 15 children's hospitals working together to improve care for hospitalized children and children with special healthcare needs.

For more information on this article, please contact Christina Bethell by e-mail at bethellc@ohsu.edu.

q&a: Cheryl Knapp and Jane Janssen on the Baldrige Process at Bronson Methodist Hospital

Joann Genovich-Richards



Cheryl Knapp

Jane Janssen

The Malcolm Baldrige National Quality Award is the nation's highest presidential honor for quality and organizational performance excellence, and in 2005 Bronson Methodist Hospital (BMH), Kalamazoo, MI, was the only healthcare recipient of the award. In addition, Solucient named BMH one of the top 100 hospitals in the United States in 2005, and BMH was the sole recipient of the 2005 Michigan Quality Leadership Award (which it first received in 2001). BMH has also been recognized for workplace excellence and its encouragement of work-life balance for its employees. It was named among the 100 best companies for working mothers by *Working Mother* in 2003, 2004, and 2005 and by *Fortune* as one of the 100 best companies to work for in 2004, 2005, and 2006.

The Green Guide placed BMH on the list of America's top 10 green hospitals in 2006, and Hospitals for a Healthy Environment presented the hospital with the Environmental Leadership Award for the last 4 years for its pioneering efforts to reduce waste and pollution. Twenty-five percent of the total waste stream was recycled in 2005. Because of the new technology BMH used to treat medical waste, the volume sent to landfills was reduced by 85%, and using microfiber mops has eliminated the use of 500,000 gallons of water and over 100 gallons of chemicals annually.

With 343 licensed beds, all with private rooms, BMH is a tertiary medical center providing inpatient and outpatient care in virtually every specialty—cardiology, orthopedics, surgery, emergency medicine, neurology, and oncology—with advanced capabilities in critical care as a Level 1 trauma center; in neurological care as a primary stroke center certified by the Joint Commission on Accreditation of Healthcare Organizations; in cardiac care as the region's only accredited chest pain center; in obstetrics as the leading center for birthing and only high-risk pregnancy center in southwest

Cheryl Knapp, MBA RN CPHQ, vice president of physician information systems for Bronson Healthcare Group (BHG), Kalamazoo, MI, has worked in the quality field for the past 15 years. She is responsible for patient safety, organizational performance improvement, accreditation, research, and home healthcare, and in 2002 and 2003, she was on the Baldrige board of examiners.

Jane Janssen, MBA RN CPHQ, has been working in the quality field for 11 years. As the director of clinical operations improvement for BHG, her responsibilities include regulatory compliance, patient safety, organizational performance improvement, and medical staff office functions. She was a state examiner in 2002 and 2003. Knapp and Janssen spoke to *JHQ* about BMH's review process for the Baldrige award.

Michigan, and in pediatrics as one of only four children's hospitals in the state.

Key Words

awards and recognition
Baldrige

q What was the role of Bronson's quality professionals in preparing for the Baldrige review processes at the national and state levels—for example, in staff preparation, documentation, and leadership development?

a Quality professionals were part of the initial team reviewing the Baldrige criteria and determining how we could apply those principles to Bronson beginning in 2000. The Baldrige application has seven categories, and although quality professionals can have an influence in each one, they can have a significant impact in three specific categories: measurement and analysis, process management, and results.

At Bronson, we had quality professionals participate in each of these three categories. For each section, a multidisciplinary team reviewed the criteria, developed or refined the process,

communicated the changes, and deployed the results. In some instances, we formalized the informal by documenting the current process. In other situations we had to develop a process following our Plan, Do, Check, Act (PDCA) improvement model.

Each year that we applied, we received a feedback report. We used this report, which highlighted our strengths and opportunities for improvement, to make improvements in the system.

In preparing for the state and national review, Bronson staff took several approaches: we held mock sessions, executive rounds, topic-specific group preparation meetings, and a 2-day leadership training retreat. We also distributed copies of the application and assembled all the supporting documentation for easy access during the survey process.

q What were the most challenging aspects of the preparation processes?

a The Baldrige examiners come from a variety of backgrounds, and many are not familiar with the healthcare industry. The Baldrige language provides a common framework for both examiners and applicants. However, as we prepared staff for the site visit, we used more of the Baldrige language to bridge the translation gap between the criteria and the processes that staff members use every day. Also, many of the criteria are written as “How do you . . . ?” We had a tendency to answer the question with an example rather than to answer by outlining the process that was part of the question. Both of these aspects were a challenge in the preparation process.

q Is there anything you would now do differently in submitting documentation and preparing for the site visits?

a Obviously we are very happy with the results! Part of the Baldrige review process is to be selected for a site visit. In September, a site visit is scheduled for October. We started the main work of preparing the organization after we received notification that we were scheduled for a site visit (our first).

Reviewing the process now, we see that we could have started preparing the organization sooner.

q What tactics are you using to sustain a high level of performance?

a In order to sustain a high level of performance, we develop a strategic plan to determine our goals and objectives for the year. During this process we clearly state our objectives and related measurable goals that are benchmarked against best-practice comparisons. We have a systematic process of measuring and communicating about our performance. We then develop action plans for change, if necessary. Last, but not least, is accountability. We tie the objectives, measures, and targets to the annual goals for our leaders, staff, and medical directors.

q What advice would you give your colleagues who are considering applying for a state or national award?

a First, get started! Dedicate some time to answering the criteria questions. You will gain from this process even if you choose not to submit an application. Next, if you choose to submit an application, the feedback report helps guide your institution toward improvement by pointing out areas that are strengths and opportunities for improvement. Finally, consider becoming a Baldrige surveyor at the state level or an examiner at the national level. For more information, contact your state or the Baldrige National Quality Award Program at 301/975-2036 or www.baldrige.nist.gov.

Joann Genovitch-Richards, PhD MBA MSN RN, is the president of Sharendipity Enterprises, Inc., a healthcare consulting firm in Sterling Heights, MI. She is JHQ's q&a co-editor.

Conference Brief Report: Update on the National Health Policy Conference

Jacqueline F. Byers

The National Health Policy Conference, sponsored by AcademyHealth and Health Affairs, was held February 6–7, 2006 in Washington, DC. Prominent national leaders from public and private sectors came together to discuss and debate current health policy issues. The purpose of this review is to briefly highlight implications for healthcare quality professionals and to refer readers to Web resources including Web casts of the presentations, Microsoft PowerPoint presentations and handouts from the speakers, and a conference summary. Those of us who work in the field of healthcare quality live in exciting and challenging times!

Current healthcare policy issues and initiatives for healthcare quality professionals to keep an eye on are

- declining Medicare reimbursement to healthcare agencies
- a cap on physician reimbursement (this may be overridden by new legislation)
- President Bush's goal of transparency regarding healthcare costs and quality so that consumers can make good decisions based on good data, including drug pricing information to become available to the public in July 2006
- changes in Medicaid to allow the disabled to have increased access to community services and institutionalized persons to be cared for in alternative settings
- demonstration projects in 10 states to investigate innovative funding and care delivery for the chronically ill
- pay for performance by Centers for Medicare & Medicaid Services (in the early planning phases)

- educating Medicare recipients to make informed choices for Part D
- healthcare information technology implementation and interoperability (the goal is real-time access to information for decision making)
- implementation of the Patient Safety Act of 2005, which calls for nonfunded patient safety organizations to allow protected analysis of near-miss and adverse events to inform system improvement
- the Agency for Healthcare Research and Quality's evidence-based practice centers, the DECIDE centers, and the Eisenberg Center for Communication (the goal of these federal agencies [the latter two in development] is to provide rapid research on evidence-based practices and to communicate them in an understandable way to all end-users from consumers to practitioners; see www.ahrq.gov/qual/)
- the Veterans Administration National Center for Patient Safety (www.patientsafety.gov/)

I encourage you to take a few moments to review these resources:

- live Web casts of the plenary sessions (www.kaisernetwork.org/healthcast/nhpc/06feb06)
- PowerPoint slides, handouts, and a conference summary (www.academyhealth.org/conferences/nhpc.htm).

Jacqueline F. Byers, PhD RN CPHQ, is professor at the School of Nursing, College of Health and Public Affairs, University of Central Florida, Orlando. She is JHQ's research editor.

Media Reviews

Lecia A. Albright, Media Editor

Reimagining America: AARP's Blueprint for the Future

AARP, www.aarp.org, 2005, free, 45 pages

Audience: Americans age 50 and older

Key Words: cost containment and management, evidence-based medicine, healthcare delivery, outcomes, resource utilization

Reimagining America: AARP's Blueprint for the Future, a working draft prepared by AARP (formerly known as the American Association of Retired Persons), provides a guideline for each American retiree to have (1) affordable quality healthcare and supportive services; (2) strong economic security; and (3) an independent, comfortable quality of life. The *Blueprint* recommends that changes be made today because "tomorrow will be here before we know it," but the actions recommended will be difficult to implement. They will involve planning, sacrifice, cutting back on spending, and putting off rewards until the future.

Basic questions are posed and answers provided regarding key healthcare issues facing the aging baby-boom population.

1. The U.S. healthcare system is the costliest on earth. Why? The system may be too big, complex, and fragmented. Resource use may be irrational and too inefficient. There may be too much waste, duplication, and redundancy.
2. What is needed? A system that is streamlined, affordable, accessible, timely, effective, and efficient. Essentially this involves providing the right care at the right time in the right place at the right price.
3. For whom? For all Americans.
4. Universal healthcare? Perhaps.
5. How? By providing uninterrupted coverage.
6. At what cost? \$65 billion to \$130 billion per year. That figure, it is asserted, would be cheaper in the long run than caring for the ever increasing numbers of the

uninsured and underinsured who have had no prior healthcare services and enter the system with complex comorbidities.

The *Blueprint* recommends the immediate overhaul of the healthcare system. Specifics on how this should be accomplished, however, are not provided. One suggestion is to visit countries that have enacted successful healthcare reform and then pilot some of their proven strategies in the United States.

Federal and state governments, private employers, nonprofit organizations, and citizens must share the financial responsibility for guaranteeing the lifestyle and healthcare entitlements discussed in this volume, because no single entity will be able to pay the enormous costs associated with providing healthcare to this aging population. Authors of the *Blueprint* suggest that the following actions be taken immediately: spend healthcare dollars more wisely; use preventive healthcare services earlier; use home- and community-based healthcare services; promote lifelong community housing; veto diversion of Social Security funds into private investment accounts; veto lump-sum 401(k) payouts; support universal 401(k) and employer matching plans; mandate savings; apply Medicare cost-cutting measures to Social Security and Medicaid programs; and employ those aged 65–74 and offer employer incentives to do so.

It is proposed that if these actions were taken immediately, they could yield realistic solutions to U.S. long-term fiscal problems. Both national and international debts could be paid, the dollar could regain value overseas, the U.S. economy would be strengthened, and the United States could gain respect worldwide. The ultimate yield is security. With the *Blueprint*, AARP offers that hope.

Reviewed by Maureen E. Lydon, MS BSN RN CPUR
CHCQM CCM

The U.S. Healthcare Certificate of Need Sourcebook

Robert James Cimasi

Beard Books, www.beardbooks.com, 2005, \$199.00, 512 pages, ISBN 1-58798-275-7

Audience: administrators, businesspeople, lawyers, legislators, physicians, policy makers, regulators

Key Words: government regulations, public policy, resource utilization

This book is a great resource for certificate-of-need information; it contains resource-related materials and addresses concerns related to certificate of need. An introductory section discusses some of the historically pivotal and troublesome aspects of statutory and regulatory-laden certificate-of-need schemes. The reference materials should be helpful to those seeking to disentangle the knotty mass of regulatory and legal issues addressed by the certificate-of-need statutes and regulations of particular states.

The certificate-of-need resources, the substance of the sourcebook, are listed in several bibliographies, including one of books, reports, and working papers; a second of relevant articles; and a third of law cases by case name.

Abstracted law cases, arranged by legal venue, are another resource in the sourcebook. A listing of law cases, arranged according to the nature of the underlying legal cause of action and linked with particular healthcare equipment, facilities, and services, is another resource. In addition, a listing by state will help users determine whether particular types of healthcare equipment, facilities, and services are subject to certificate-of-need regulation.

For those seeking answers to particular real-life problems related to certificate of need, the resource materials in the sourcebook may be generally instructive. However, statutes, case laws, and regulations that impinge on the certificate-of-need mechanisms of individual states may change over time, thus eroding the timeliness and potential helpfulness of the sourcebook. The fragmentation and decentralization of the U.S. healthcare system may lessen the practical value of resource materials in this book. In any case, this reference should not be used as a surrogate for the counsel of qualified professionals regarding specific problems or

issues pertaining to certificate of need.

Reviewed by Leo Uzych, JD MPH

The Disease Manager's Handbook

Rufus Howe

Jones and Bartlett Publishers, www.jbpub.com, 2005, \$46.95, 245 pages, ISBN 0-7637-4783-1

Audience: case managers, disease managers, nurses, physicians

Key Words: care planning, case and care management, patient health information

According to Howe, "Disease management practice is the sum of incorporating patient characteristics, formulating the clinical question, crafting an optimal intervention, and delivering that intervention to the patient in a way that positively affects financial and clinical outcomes."

This handbook provides a basic road map for the disease management professional. It can be used as a graduate school textbook and by healthcare professionals seeking to diversify their careers. The discussion of how disease management may complement the case manager's role should be enlightening for case managers. Chapters 8 and 9 will be helpful for novice disease managers trying to develop an organization's program(s) in disease management.

Chapter 16 focuses on understanding and following the plan of care. The author categorizes three issues involved in providing healthcare instructions to patients:

- awareness of the differences between patients' and physicians' expectations concerning what information is given
- the amount of information given by physicians, the lack of basic knowledge on the part of patients, and patients' failure to comply with physicians' instructions
- the language and vocabulary used to instruct.

Doctors are aware that their patients are not familiar with medical terminology, but they are also under time constraints when providing instructions.

Improving communication should be the mutual goals of the physician and the patient. The disease manager can assist in reaching this goal through techniques such as creating

a clinic visit agenda and a patient-centered instruction sheet. Samples are provided in the book.

The remaining chapters address health promotion activities such as exercise and the management of stress. These are valuable additions. I highly recommend this book for healthcare quality professionals who work in integrated case management and disease management roles.

Reviewed by Teresa I. Gonzalvo, MPA RN CPHQ LNC

Savvy Patient: The Ultimate Advocate for Quality Health Care

Mark C. Pettus

Capital Books, Inc., www.capital-books.com, 2004, \$19.95, 340 pages, ISBN 1-931868-80-8

Audience: case managers, healthcare consumers, healthcare professionals

Key Words: allied healthcare professionals, case and care management, communications, consumer satisfaction, education, health promotion, patient health information, public health

When patients enter the healthcare system, they often encounter massive amounts of overwhelming information. Not only is this experience frustrating, but it adds to the patient's anxiety about his or her medical condition and the myriad of healthcare decisions that have to be made.

This book acknowledges that, generally, a patient simply wants to know what the problem is, what needs to happen to get the problem resolved, and what the available options are to resolve them. A patient's confusion often begins with the initial encounter with a healthcare professional and continues through the entire process. They receive multiple pieces of paper detailing information about testing, care, and discharge instructions. Healthcare providers expect patients to digest, process, and understand a massive amount of

information during one of the most stressful times in their lives.

Mark Pettus's goal of "demystifying the average healthcare system" has been achieved in *The Savvy Patient*. The book heightens the average healthcare consumer's knowledge about the dynamic changes that are shaping the current healthcare system. These changes originate from sophisticated technology aimed at achieving a more efficient healthcare delivery system. But sometimes even simple processes appear complex to those who are facing a stressful medical event in their lives.

The book uses a simplistic approach to explore the healthcare continuum. It empowers patients with knowledge to help serve their best interests, such as what inquiries should be made regarding one's healthcare status and how to confront challenges in the typical healthcare encounter.

Pettus takes readers on their healthcare journey one step at a time and provides insights on the processes that they will encounter. The chapters need not be read in sequence; each can be a resource for specific needs. The book is handy and convenient to use and can be viewed as a patient's personal resource for navigating through healthcare experiences. Another of the book's assets is the "take-home points" at the end of every chapter, encapsulated summaries of the most relevant information from that chapter.

The book gives patients an overall understanding of the key aspects of the healthcare delivery system and may play an important role in creating a partnership between patients and providers. In a partnership model, savvy patients are those who can actively participate to enhance their own experiences while assisting providers in the continuous improvement of the healthcare delivery system.

Reviewed by Tess P. Panizales, MSN RN

Lecia A. Albright, CPHQ, is the JHQ media editor and the principal and owner of LARA Consulting, LLC, located in Fredericksburg, VA. Her e-mail address is laraconsulting@adelphia.net.

Quality NETWORK

Robert J. Rosati and Daniel van Leeuwen, Quality NETWORK Editors

“Quality NETWORK” offers reviews of selected Web sites relevant to healthcare quality professionals. The editors welcome comments and feedback on the column as well as suggestions for further reviews. To read previous reviews that have appeared in the journal, visit www.NAHQPlus.org, the exclusive Web site for NAHQ members.

Office of Human Subjects Research

<http://ohsr.od.nih.gov/>

Key Words: ethics, research

The Office of Human Subjects Research (OHSR) operates within the Office of Deputy Director for Intramural Research, National Institutes of Health (NIH). NIH is part of the U.S. Public Health Service, an agency within the U.S. Department of Health and Human Services (DHHS). Researchers in the NIH Intramural Research Program (IRP) conduct and collaborate on a number of research activities, including research involving human subjects. The purpose of OHSR is to help IRP investigators understand and comply with the ethical guidelines and regulatory requirements for research involving human subjects.

The site contains a wealth of knowledge pertaining to human subjects in research. To find information quickly, go to the site map for OHSR informational sheets and forms—most were updated in August 2000. The site map allows the user to quickly select an area of interest. For example, *Sheet 3* pertains to the criteria for institutional review board approval of research involving human subjects. The material discusses equitable selection of subjects; minimization of risk to subjects; and the securing of informed consent from the subject or legally authorized representative. *Sheet 8* includes frequently asked questions sent to OHSR. One common question concerns the difference between the Office for Human Research Protection (OHRP) and OHSR. OHRP has oversight and educational responsibilities wherever DHHS funds are used to conduct research involving human subjects; OHSR functions are limited to the IRP of NIH.

I had some difficulty reviewing the links to NIH, OHRP, and the Food and Drug Administration. I completed a technical support form, and assistance was provided within 24 hours. OHSR’s e-mail, address, telephone, and fax numbers are available for future contact. Although certain sections are only for NIH staff, the Web site would be useful for healthcare quality professionals involved in research.

Reviewed by Sandra E. Ward, MA MS RN CPUR CPHQ

Patient Powered: Patient-Centered Healthcare in Whatcom County

www.patientpowered.org

Key Words: disease management, patient- and family-centered care, patient safety

PatientPowered.org was created by patients in Whatcom County, WA, as part of Pursuing Perfection, a major initiative of the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement. The initiative was undertaken to achieve models of excellence by redesigning systems to create dramatic improvements in major care processes.

According to its Web site, the local Whatcom County project’s goal is to create a patient-centered, communitywide chronic care management system that will deliver recommended care 100% of the time. The home page reads: “You have control. You have options. You have help.”

The Shared Care Plan, a free, easy-to-use, personal health record that enables patients to organize and store vital health information to share with family, physicians, or others as appropriate, is one of the more noteworthy features of the site. According to the description, this self-management care plan can help patients improve their understanding of their own health.

Another excellent feature is the self-management tools for such chronic diseases as diabetes and heart failure. The site provides extensive information about these chronic diseases, along with links to several external sites.

QUALITY NETWORK

The major drawback of this site is that it does not appear to have been updated since 2004–2005, so some of the documents may no longer be available.

I bookmarked the site because it is an excellent example of a patient-focused Web site with easy readability and applicability.

Reviewed by Pamela Scarrow, CPHQ

Bureau of Labor Statistics— Occupational Injuries and Illnesses

<http://data.bls.gov/PDQ/outside.jsp?survey=sh>

Key Words: administration and management, benchmarking, indicator monitoring

The U.S. Department of Labor provides an easily searchable site that lists occupational injury data from 1989 to 2001. The site contains several drop-down menus that allow the user to select the criteria for formulating displays of desired data in either graphs or tables. Examples of search queries include the year of injury, the type of industry in which the injury occurred, and categories such as “cases involving days away from work,” “days of restricted work activity,” and

“lost work days.” Healthcare professionals can choose from the services listing of occupational injuries. This is an excellent site for benchmarking organization-specific data on work-related injuries.

Reviewed by Lenard L. Parisi, MA RN CPHQ FNAHQ

Help Identify and Review Sites

The JHQ team invites you to help identify and review Web sites. A review consists of the name of the site or sponsoring organization, a URL reference, key words, the intent of the site, and comments about ease of navigation, value, pertinence to the healthcare quality professional, timeliness, and cost, if any. Please forward—via e-mail—questions, sites for review, or, better yet, sites with reviews, to Quality NETwork co-editor Robert Rosati at robert.rosati@vnsny.org.

Robert J. Rosati, PhD, is director of outcomes analysis and research at the Center for Home Care Policy and Research, Visiting Nurse Service of New York, New York, NY. His e-mail address is robert.rosati@vnsny.org.

Daniel van Leeuwen, MPH RN CPHQ CHE, is director of professional and community standards at St. Peter's Addiction Recovery Center in Guilderland, NY.

Quality Products and Resources

Luc R. Pelletier

This *JHQ* feature provides members with interesting up-to-the-minute resources that will help them navigate in the constant flood of healthcare quality information. Brief descriptions of recently released media are provided, as well as ordering and Internet access information. New product announcements and company contact information are also provided.

Product

Healthgate Leaps Toward Fast Integration of Latest Clinical Evidence in Support of Hospital-Wide Quality Improvement Initiatives

Health Language, Inc., a leading supplier of medical vocabulary and concept-based technology, and HealthGate Data Corporation are working together to introduce Health Language's Language Engine (LE) Technology into HealthGate's flagship product, Quality Architect. This integration accelerates the creation, maintenance, and deployment of evidence-based order sets, pathways, and clinical guidelines by automating the indexing and mapping of evidence-based content into a variety of clinical information systems.

When hospitals deploy sophisticated healthcare quality improvement systems to consolidate content, the time spent mapping and maintaining links to the standard terminology systems used by vendors of electronic health information systems may be substantial. For hospitals that use computerized physician order entry systems (CPOES), it is also critical to be able to correlate evidence-based recommendations for a specific care decision to the correct terms in the CPOES. HealthGate selected the LE to implement transparent, automated synchronization of terminology and standards in its Quality Architect solution, resulting in dramatic time reductions in the publication of approved clinical evidence and hospitalwide deployment of updated, relevant recommendations for improved quality of care and patient safety.

In the past, the complexities of healthcare terminology and code sets have slowed the systemwide deployment of evidence-based practices. HealthGate's decision to integrate LE into Quality Architect provides a solution to this problem, enabling intelligent, automated management of clinical health data by indexing and using standard clinical terminologies such as SNOMED-CT and Rx Norm and increasing efficient collaboration between clinicians and their teams.

Further information on Health Language, Inc., is available at www.healthlanguage.com or by calling 303/307-4400.

Resources

SAMHSA Unveils State Substance Abuse Data from 2004 National Survey on Drug Use and Health

California and Wisconsin had increases in underage alcohol use between 2002–2003 and 2003–2004, while Michigan and South Carolina showed decreases, according to a new state-by-state report from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

The report, *State Estimates of Substance Use from the 2003–2004 National Surveys on Drug Use and Health*, issued in April, estimates state rates of illegal drug use, binge and underage drinking, serious mental illness, and tobacco use. SAMHSA combined 2 years of data from the annual *National Survey on Drug Use and Health* to enhance the precision of estimates for the less populous states.

The report shows that in California the rate of 12–20-year-olds using alcohol in the past month increased from 24.7% to 26.3%, while in Wisconsin the rate increased from 34.7% to 38.3%. Michigan and South Carolina, however, showed decreases in underage drinking—from 31.8% to 30.2% in Michigan and from 27.3% to 24.1% in South Carolina.

The report is available on the Web at www.oas.samhsa.gov.

Institute of Medicine Report: United States Lacks Adequate Capacity to Treat People with Sleep Disorders

According to a new report from the Institute of Medicine (IOM), currently too few scientists study sleep disorders, and too few healthcare professionals are trained to diagnose and treat sleep problems. Between 50 million and 70 million Americans struggle with chronic sleep disorders, which cost the United States hundreds of billions of dollars yearly in medical expenses, lost productivity, accidents, and other expenses.

The report recommends boosting the training of all healthcare providers in sleep medicine to improve diagnosis and care for people experiencing sleep problems. It urges increased research into the causes of sleep disorders and sleep loss as well as new, more effective ways to diagnose and treat these conditions. The report also calls for a national public awareness campaign to increase Americans' understanding of the importance of sleep and the consequences of sleep deprivation.

The full report is available at www.nap.edu/catalog/11617.html.

New Report from the Commonwealth Fund Reviews Quality Through the Eyes of Patients

Two new cross-national studies of patients' healthcare experiences find that the United States—the country that spends more on healthcare than any other—fares comparatively poorly on a number of important health system indicators.

For the report, *Mirror, Mirror, on the Wall: An Update on the Quality of American Health Care Through the Patient's Lens*, Commonwealth Fund president Karen Davis and colleagues

analyzed 2004 and 2005 patient survey data for Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States, using a framework developed by the Institute of Medicine to evaluate the quality of a healthcare system. Out of 51 indicators of healthcare quality, the United States ranked first on 6 indicators and ranked last or tied for last on 27, including measures of patient safety, patient-centeredness, efficiency, and equity. Delivery of preventive care was one area in which the United States performed comparatively well.

The full report is available at www.cmwf.org/publications/publications_show.htm?doc_id=364436&#doc364436.

California HealthCare Foundation Publishes National Healthcare Costs

Now in its third edition, *Health Care Costs 101* concisely presents the latest national health spending trends. This year, for the first time, the annual snapshot examines how contributions from households, business, and government are combined to finance both public and private health coverage.

The report finds that the growth of national spending on healthcare—totaling nearly \$1.9 trillion in 2004, or \$5 billion a day—slowed for the second consecutive year but is still outpacing inflation.

Other notable findings include the following: (1) the amount spent per person was \$6,280 in 2004, an increase of 74% over 1994 levels; and (2) growth in prescription drug spending fell below 10% for the first time in a decade and is now growing at levels similar to those of other health services.

The full report is available at www.chcf.org.

Compiled by Luc R. Pelletier, JHQ's editor in chief