

NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

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

NQF #: 1904	NQF Project: Healthcare Disparities Project
(for Endorsement Maintenance Review)	
Original Endorsement Date: Most Recent Endorsement Date:	
BRIEF MEASURE INFORMATION	
De.1 Measure Title: Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	
Co.1.1 Measure Steward: Agency for Healthcare Research and Quality	
De.2 Brief Description of Measure: These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey that includes the following domains: Patient-provider communication; Complementary and alternative medicine; Experiences of discrimination due to race/ethnicity, insurance, or language; Experiences leading to trust or distrust, including level of trust, caring and confidence in the truthfulness of their provide; and Linguistic competency (Access to language services). Samples for the survey are drawn from adults who have at least one provider's visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the Core Clinician/Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifiers). Two composites can be calculated from the item set: 1) Providers are caring and inspire trust (5 items), and 2) Providers are polite and considerate (3 Items).	
2a1.1 Numerator Statement: We recommend that the Clinicians/Groups' Health Literacy Practices measures be calculated using the top box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses. Two composites can be calculated from the item set: 1) Providers are caring and inspire trust (5 items), and 2) Providers are polite and considerate (3 Items).	
2a1.4 Denominator Statement: Adults with a visit to the provider for which the survey is being fielded within the last 12 months who responded to the item.	
2a1.8 Denominator Exclusions: Exclusions are made when sample is drawn from provider records. Only patients 18 or older and those who have had a visit with a provider in the last 12 months are sampled. Core question 4 verifies that the respondent got care from the provider in the last 12 months.	
1.1 Measure Type: Patient Engagement/Experience	
2a1. 25-26 Data Source: Patient Reported Data/Survey	
2a1.33 Level of Analysis: Clinician : Group/Practice, Clinician : Individual	
1.2-1.4 Is this measure paired with another measure? No	
De.3 If included in a composite, please identify the composite measure (title and NQF number if endorsed):	

STAFF NOTES (issues or questions regarding any criteria)
Comments on Conditions for Consideration:
Is the measure untested? Yes <input type="checkbox"/> No <input type="checkbox"/> If untested, explain how it meets criteria for consideration for time-limited

endorsement:
1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (check De.5): 5. Similar/related <u>endorsed</u> or submitted measures (check 5.1): Other Criteria:
Staff Reviewer Name(s):

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

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See [guidance on evidence](#).
Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.
[\(evaluation criteria\)](#)

1a. High Impact: H M L I
(The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.)

De.4 Subject/Topic Areas (Check all the areas that apply):
De.5 Cross Cutting Areas (Check all the areas that apply): Disparities, Patient and Family Engagement

1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, Patient/societal consequences of poor quality

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

1a.3 Summary of Evidence of High Impact (Provide epidemiologic or resource use data):
Among the strategies that have been advocated for reducing racial/ethnic differences in patient experiences is the provision of "culturally competent" care.(1,2) The National Quality Forum (NQF) (p. 2) recently defined cultural competency as the "ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based, and equitable."(3) The following is a direct quote from NQF's "A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report."

"For too long healthcare received by minority populations has been of poorer quality; even when factors such as access, health insurance, and income are taken into account. Unless these inequities are addressed and care becomes more patient centered, these disparities in health and healthcare will persist. One major contributor to healthcare disparities is a lack of culturally competent care.

Even as healthcare systems improve, without the provision of culturally appropriate services, medical errors, misunderstandings, and a lack of patient adherence may still increase because of differences in language or culture. Providing culturally appropriate services not only has the potential to reduce disparities and improve outcomes, but it also can create greater patient satisfaction and help to increase the efficiency of clinical and support staff."

Many organizations have set about to improve the cultural competence of health care providers. For example, the Department of Health and Human Services (HHS) Office of Minority Health has developed a set of Cultural Competency Curriculum Modules(4) that aim to equip providers with cultural and linguistic competencies to help promote patient-centered care based on the National Standards on Culturally and Linguistically Appropriate Services. Another example, which is being administered by the Health Resources and Services Administration, is the Unified Health Communication, a Web-based course for providers that integrates concepts related to health literacy with cultural competency and LEP.(5) It is therefore important to have measures of how well these efforts to improve cultural competence are succeeding.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) project has resulted in a set of standardized survey instruments that can be used to collect reliable information from patients about the care they have received. These evaluations provide important information about how well health plans and providers meet the needs of the people they serve.(6) CAHPS data have been used to assess racial/ethnic and language differences in patient experiences with care.(7-10) However, there are concerns that the CAHPS instrument does not fully capture domains of care of particular relevance to people of color.(1) The CAHPS Cultural Competence Item Set addresses this gap by assessing aspects of cultural competency not adequately addressed

in the existing CAHPS surveys.

- 1a.4 Citations for Evidence of High Impact cited in 1a.3:**
1. Ngo-Metzger Q, Telfair, J., Sorkin, D., Weidmer, B., Weech-Maldonado, R., Hurtado, M., and Hays, R.D.,. Cultural Competency and Quality of Care: Obtaining the Patient's Perspective. NY: Commonwealth Fund; 2006.
 2. Weech-Maldonado R, Dreachslin JL, Dansky KH, et al. Racial/ethnic diversity management and cultural competency: The case of Pennsylvania hospitals. *Journal of Healthcare Management* 2002;47:111-126.
 3. National Quality Forum. A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency. Washington DC: National Quality Forum; 2008.
 4. U.S. Department of Health and Human Services, Office of Minority Health. Think Cultural Health: bridging the health care gap through cultural competency continuing education programs. Available at: www.thinkculturalhealth.hhs.gov. Accessed January 31, 2012.
 5. U.S. Department of Health and Human Services Health Resources and Services Administration. Unified health communication (UHC): addressing health literacy, cultural competency, and limited English proficiency. Available at: <http://www.hrsa.gov/publichealth/healthliteracy/index.html>. Accessed January 31, 2012.
 6. Crofton C, Lubalin JS, Darby C. Foreword. *Medical Care* 1999;37:MS1-MS9.
 7. Weech-Maldonado R, Morales LS, Spritzer K, et al. Racial and ethnic differences in parents' assessments of pediatric care in Medicaid managed care. *Health Services Research* 2001;36:575-594.
 8. Weech-Maldonado R, Morales LS, Elliott M, et al. Race/ethnicity, language, and patients' assessments of care in Medicaid managed care. *Health Services Research* 2003;38:789-808.
 9. Weech-Maldonado R, Elliott MN, Morales LS, et al. Health plan effects on patient assessments of Medicaid managed care among racial/ethnic minorities. *Journal of General Internal Medicine* 2004;19:136-145.
 10. WeechMaldonado R, Fongwa MN, Gutierrez P, et al. Language and regional differences in evaluations of Medicare managed care by Hispanics. *Health Services Research* 2008;43:552-568.

1b. Opportunity for Improvement: H M L I

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

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

Organizations that field the CAHPS Clinician & Group Survey may want to use this item set to inform consumers, to provide feedback to providers, and to spur improvements in patients' experiences. Health care organizations using this item set can use the composite measures for benchmarking and reporting at the group level. For example, a health system may report the composite measures listed above to compare performance across provider groups.

At the level of individual providers, health care organizations may want to share item-level scores in order to help providers better understand the behaviors that promote effective communication with a diverse patient population, such as minimizing negative communication behaviors (e.g., interrupting patients, talking too fast). This item set is intended to generate data that health care providers can use to improve their cultural competence by:

- Identifying specific topic areas for quality improvement.
- Recognizing particular behaviors that inhibit effective communication.
- Measuring the effect of behaviors that promote effective communication.

Providers can identify their strengths and weaknesses by topic area as well as for individual items by conducting different kinds of analyses. These analyses can help them understand how their performance on the composite measures and individual items compares to that of other providers; assess the extent to which survey responses differ by the race, ethnicity, or language of respondents; and determine which topics are driving performance on the overall rating measure. For example, analyses of data from the field test pointed to three domains that were highly correlated with the overall ratings for providers:

- Provider are polite and considerate (composite measure)
- Providers are caring and inspire trust (composite measure)
- Equitable treatment (individual items)

Having identified opportunities for improvement and embarked on quality improvement activities, the providers can then field the items again to evaluate the success of improvement activities.

In addition, patients can use information from the measures to help make better and more informed choices about their health care.

1b.2 Summary of Data Demonstrating Performance Gap (*Variation or overall less than optimal performance across providers*): **[For Maintenance** – *Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]

The U.S. Department of Health and Human Services (HHS) has long recognized the importance of ensuring quality and safety through the provision of culturally and linguistically appropriate care. In 2000, the Office of Minority Health (OMH) promulgated the National Standards for Culturally and Linguistically Appropriate Standards in Health Care. Over a decade later, OMH has launched the National CLAS Standards Enhancement Initiative in recognition of both the advancements in cultural competence of the past decade and the need to assist individuals and organizations in the implementation of the National CLAS Standards because many organizations have not made much progress. The enhanced National CLAS Standards, scheduled for release in March 2012, is subtitled, "A Blueprint for Advancing and Sustaining CLAS Practice and Policy."⁽¹⁾ It contains relevant, practical and up-to-date guidance and materials for individuals and organizations seeking to apply the National CLAS Standards.

An example of where performance comes up short is in the provision of language assistance. Approximately 13% of individuals with limited English proficiency and had a usual source of care did not receive language assistance. ⁽²⁾ For non-Hispanics, however, that percentage increased to 36%. Furthermore, only 50% of individuals with limited English proficiency (compared with 85% overall) did not have a usual source of care,⁽²⁾ suggesting that language barriers may inhibit access to care. Other performance gaps are evident in CAHPS benchmarking data, which shows that between only 59 and 76 of Medicaid beneficiaries (depending on the state) reported that their clinicians always exhibited good communication practices such as explaining things clearly and listening to what they had to say.⁽²⁾

1b.3 Citations for Data on Performance Gap: **[For Maintenance** – *Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]

1. U.S. Department of Health and Human Services, Office of Minority Health. Forthcoming March 2012. National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Practice and Policy.
2. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. 2010 National Healthcare Disparities Report. AHRQ Publication No. 11-0005. Agency for Healthcare Research and Quality: Rockville, MD, March 2011.

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

A 2001 Commonwealth Fund survey found that African Americans, Asian Americans, and Hispanics are more likely than Whites to experience difficulty communicating with their physician, to feel that they are treated with disrespect when receiving care, and to feel they would receive better care if they were of a different race or ethnicity.⁽¹⁾ Numerous studies have shown that that minority Americans are more likely to perceive discrimination and report mistrust of health care providers, leading to less satisfaction with their health care. ⁽²⁻⁶⁾

Studies using the National Consumer Assessments of Healthcare Providers and Systems (CAHPS?) Benchmarking Database have shown that racial/ethnic minorities have worse reports of care than Whites in commercial, Medicare, and Medicaid managed care. ⁽⁷⁻¹²⁾ The 2010 National Healthcare Disparities Report (NHDR) tracked CAHPS patient-provider communication from 2002-2007.⁽¹³⁾ It found:

- In all years, Hispanics were significantly more likely than non-Hispanic Whites to report poor communication.
- In 4 of 6 years, Black patients were more likely than Whites to report poor communication with health providers; the exceptions were 2006 and 2007.
- In 5 of 6 years, Asians were more likely than Whites to report poor communication; the exception was 2007.

According to the 2005 California Health Interview Survey, 10% of Latino asthmatics reported that had a hard time understanding their doctor, compared to 3% of non-Hispanic Whites. Californian asthmatics with limited English proficiency were also more likely to report problems than native English speakers or asthmatics that speak English very well (13% versus 3% and 4% respectively). Those adults who have problems understanding their doctors are more likely than those who have no problems to visit the ED/urgent care for asthma care (23% v. 13%) and were less likely to have an asthma management plan (27% v. 38%).⁽¹⁴⁾

Results from the CAHPS Cultural Competence Item Set have been similar. For example,

- Blacks reported the most discrimination due to race/ethnicity (12%), while Whites reported the least discrimination (6%). Logistic regression results show that respondents who were Black had higher odds of reporting discrimination based on race/ethnicity than White respondents.⁽¹⁵⁾
- One study found that African-Americans and Latinos were less likely than Whites to report poor cultural competency as measured by the CAHPS Cultural Competence Item Set. The authors posit this is because all of the patients were recruited from

the safety-net setting. Many more of the White patients seeking care in these settings are homeless, use illicit substances, or have ongoing psychiatric illness than Latino and African-American patients. It may be that White patients experience less culturally competent care not because of their race but because of these other co-morbidities, although further research will be needed to fully understand why Whites report less culturally competent care in this setting.(16)

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

1. Commonwealth Fund. 2001 Health Care Quality Survey. Available at: <http://www.commonwealthfund.org/Surveys/2001/2001-Health-Care-Quality-Survey.aspx>. Accessed February 1, 2012.
2. LaVeist TA, Nickerson KJ, Bowie JV. Attitudes about racism, medical mistrust, and satisfaction with care among African American and white cardiac patients. *Med Care Res Rev.* 2000;57 Suppl 1:146-161.
3. Bird ST, Bogart LM, Delahanty DL. Health-related correlates of perceived discrimination in HIV care. *AIDS Patient Care STDS.* Jan 2004;18(1):19-26.
4. Hausmann LR, Kressin NR, Hanusa BH, Ibrahim SA. Perceived racial discrimination in health care and its association with patients' healthcare experiences: does the measure matter? *Ethn Dis.* Winter 2010;20(1):40-47.
5. Benkert R, Peters RM, Clark R, Keves-Foster K. Effects of perceived racism, cultural mistrust and trust in providers on satisfaction with care. *J Natl Med Assoc.* Sep 2006;98(9):1532-1540.
6. Sorkin DH, Ngo-Metzger Q, De Alba I. Racial/ethnic discrimination in health care: impact on perceived quality of care. *J Gen Intern Med.* May 2010;25(5):390-396.
7. Weech-Maldonado R, Fongwa MN, Gutierrez P, Hays RD. Language and regional differences in evaluations of Medicare managed care by Hispanics. *Health Services Research.* Apr 2008;43(2):552-568.
8. Weech-Maldonado R, Morales LS, Elliott M, Spritzer K, Marshall G, Hays RD. Race/ethnicity, language, and patients' assessments of care in Medicaid managed care. *Health Services Research.* Jun 2003;38(3):789-808.
9. Weech-Maldonado R, Gutierrez P, Hays R. Hispanic ethnicity, language, and patient experiences with medicare managed care. *Gerontologist.* Oct 2004;44:294-294.
10. Weech-Maldonado R, Elliott MN, Morales LS, Spritzer K, Marshall GN, Hays RD. Health plan effects on patient assessments of medicaid managed care among racial/ethnic minorities. *Journal of General Internal Medicine.* Feb 2004;19(2):136-145.
11. Morales LS, Elliott MN, Weech-Maldonado R, Spritzer KL, Hays RD. Differences in CAHPS (R) adult survey reports and ratings by race and ethnicity: An analysis of the national CAHPS (R) benchmarking data 1.0. *Health Services Research.* Jul 2001;36(3):595-617.
12. Fongwa MN, Cunningham W, Weech-Maldonado R, Gutierrez PR, Hays RD. Reports and Ratings of Care: Black and White Medicare Enrollees. *Journal of Health Care for the Poor and Underserved.* Nov 2008;19(4):1136-1147.
13. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. 2010 National Healthcare Disparities Report. AHRQ Publication No. 11-0005. Agency for Healthcare Research and Quality: Rockville, MD, March 2011.
14. Babey SH, Meng YY, and Jones M. Many Californians with Asthma Have Problems Understanding Their Doctor. Los Angeles, CA: UCLA Center for Health Policy Research, 2009.
15. Weech-Maldonado R, Hall A, Bryant T, Jenkins KA, Elliott MN. Does Perceived Discrimination Affect Patient Experiences with Health Care? *Medical Care* (under review).
16. Stern RJ, Fernandez A, Jacobs EA, Neilands TB, Weech-Maldonado R, Quan J, Carle A, Seligman HK. Risk Factors for Reporting Poor Cultural Competency Among Patients with Diabetes in Safety Net Clinics. *Medical Care* (under review).

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
 Is the measure focus a health outcome? Yes No If not a health outcome, rate the body of evidence.

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

Quantity	Quality	Consistency	Does the measure pass subcriterion 1c?
M-H	M-H	M-H	Yes <input type="checkbox"/>
L	M-H	M	Yes <input type="checkbox"/> IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No <input type="checkbox"/>

NQF #1904 Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set

M-H	L	M-H	Yes <input type="checkbox"/> IF potential benefits to patients clearly outweigh potential harms: otherwise No <input type="checkbox"/>
L-M-H	L-M-H	L	No <input type="checkbox"/>
Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service		Does the measure pass subcriterion1c? Yes <input type="checkbox"/> IF rationale supports relationship	
<p>1c.1 Structure-Process-Outcome Relationship (<i>Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome</i>):</p> <p>Numerous studies link the domains measured in the CAHPS Cultural Competence Item Set to access, adherence, satisfaction, and other health outcomes. For example,</p> <ul style="list-style-type: none"> • Thom et al.(1) found that patients with low levels of trust were less likely to adhere to their physician's advice, and were more likely to report not receiving the services they requested or needed. Similarly, patients with lower levels of trust report lower levels of satisfaction with the patient-provider relationship.(1) Several studies have observed lower levels of patient trust among racial and ethnic minorities.(2-5) In adjusted analysis of the field test results of the CAHPS Cultural Competence Item Set, reports of high Trust in physician (measured by the Providers Are Caring and Inspire Trust Composite) were associated with lower likelihood of poor glycemic control (OR 0.59, CI: 0.41, 0.84).(6) • Patient perceptions of culturally competent care, as measured by the CAHPS Cultural Competence Item Set and the two composites in particular, are associated with lower emotional burden among diabetic patients, suggesting that aspects of the physician-patient relationship may significantly influence patients' experience of diabetes.(7) • Research has found that perceived discrimination is associated with various negative health outcomes. For example, Bird et al.(8) found that racially- and socioeconomically-based discrimination were associated with greater levels of depression and post-traumatic stress symptoms, greater severity of AIDS-related symptoms, and lower perceived general health. Similarly, Crowe et al.(9) in a study of older African Americans with diabetes found that those that reported discrimination were more likely to experience cognitive decline. Perceived discrimination has also been found to have a negative effect on satisfaction with care.(10-12) In a fielding of the CAHPS Cultural Competence Item Set, Medicaid beneficiaries who reported discrimination based on their race/ethnicity had worse patient experiences than those who did not perceive discrimination.(13) • Studies show that language barriers have a demonstrable negative impact on communication, satisfaction, and appropriate health care utilization. A growing body of literature suggests that language assistance interventions such as oral interpretation can have a positive effect on patient satisfaction and comprehension, and improvements on health care delivery measures such as increases in the amount of time spent with patients, reduction in diagnostic testing disparities among English speaking patients versus limited English proficient (LEP) patients, higher clinic return rates, and increases in primary care services utilization.(14) • Patients' inability to understand providers verbal and written communication can affect their ability to understand medical advice, take medicine correctly and safely, engage in self-care behaviors, and make informed decisions about their health care. These things contribute to patient outcomes and practice liability.(15) <p>Furthermore, there is growing evidence that cultural competence strategies are a means of quality improvement. Certain cultural competence interventions appear to affect health services utilization, satisfaction, and increases in knowledge, although subsequent impacts on provider or patient behavior and/or health outcomes have not been explored.(14) For example, a review of 64 articles that evaluated cultural competence training as a strategy to improve the quality of health care in minority populations found excellent evidence for improvement in provider knowledge, good evidence for improvement in provider attitudes and skills, and good evidence for improvement in patient satisfaction. (16)</p> <p>Patients are an important source of information as to whether providers are delivering culturally competent care. The survey development team conducted a literature review and preliminary research to investigate the usefulness of a CAHPS survey to gather information on patients' assessments of the cultural competence of health care providers. This research was published by the Commonwealth Fund in: Ngo-Metzger Q, Telfair J, Sorkin DH, Weidmer B, Weech-Maldonado R, Hurtado M, Hays RD. Cultural Competence and Quality of Care: Obtaining the Patient's Perspective. New York: The Commonwealth Fund; October 2006. (Available at: http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2006/Oct/Cultural%20Competency%20and%20Quality%20of%20Care%20Obtaining%20the%20Patients%20Perspective/Ngo%20Metzger_cultcompqualitycareobtainpatientperspect_963%20pdf.pdf)</p> <p>The survey development team included individuals with experience in the field of cultural competence who have participated in numerous expert meetings over the preceding years that discussed the important aspects of cultural competence to measure. Development of the survey involved the following five steps: 1) Evaluating existing CAHPS surveys to identify existing items that</p>			

addressed the domains of interest; 2) Conducting a literature review in order to identify existing instruments or item sets that had been used in the past to collect data on cultural competency from the patient's perspective; 3) Placing a Federal Register notice with a call for measures; 4) Reviewing and adapting existing measures in the public domain; and 5) Writing survey items for each of the proposed cultural competency domains that were not currently addressed by CAHPS or existing instruments.

References:

1. Thom DH, Kravitz RL, Bell RA, et al. Patient trust in the physician: relationship to patient requests. *Family Practice* 2002;19:476-483
2. Hunt KA, Gaba A, Lavizzo-Mourey R. Racial and ethnic disparities and perceptions of health care: does health plan type matter? *Health Services Research* 2005;40:551-576
3. Schnittker J. Social distance in the clinical encounter: interactional and sociodemographic foundations for mistrust in physicians. *Social Psychology Quarterly* 2004;67:217-235
4. Meredith LS, Siu AL. Variation and quality of self-report health data: Asians and Pacific Islanders compared with other ethnic groups. *Medical Care* 1995;1120-1131
5. LaVeist TA, Nickerson KJ, Bowie JV. Attitudes about racism, medical mistrust, and satisfaction with care among African American and white cardiac patients. *Medical Care Research and Review* 2000;57:146-161
6. Fernandez A, Seligman H, Quan J, Stern RJ, Jacobs EA. Associations between Aspects of Culturally Competent Care and Diabetes Outcomes among Ethnically Diverse Patients with Diabetes. *Medical Care* (under review).
7. Slean GR, Jacobs EA, Lahiff M, Fisher L, PhD4, Fernandez F. Diabetes Distress is Associated with Reports of Suboptimal Culturally Competent Care. *Medical Care* (under review).
8. Bird ST, Bogart LM, Delahanty DL. Health-related correlates of perceived discrimination in HIV care. *AIDS patient care and STDs* 2004;18:19-26
9. Crowe M, Sartori A, Clay OJ, et al. Diabetes and cognitive decline: investigating the potential influence of factors related to health disparities. *Journal of aging and health* 2010;22:292-306
10. Benkert R, Peters RM, Clark R, et al. Effects of perceived racism, cultural mistrust and trust in providers on satisfaction with care. *Journal of the National Medical Association* 2006;98:1532-1540
11. Sorkin DH, Ngo-Metzger Q, De Alba I. Racial/ethnic discrimination in health care: impact on perceived quality of care. *Journal of General Internal Medicine* 2010;25:390-396
12. Hausmann LRM, Hannon MJ, Kresevic DM, et al. Impact of Perceived Discrimination in Healthcare on Patient-Provider Communication. *Medical Care* 2011;49:626-633
13. Weech-Maldonado, Hall A, Bryant T, Jenkins KA, Elliott MN. Does Perceived Discrimination Affect Patient Experiences with Health Care? *Medical Care* (under review).
14. Fortier J. P., Bishop, D. 2004. Setting the agenda for research on cultural competence in health care: final report. Edited by C. Brach. Rockville, MD: U.S. Department of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality.
15. DeWalt DA, Callahan LF, Hawk VH, Brouckson KA, Hink A, Rudd R, Brach C. Health Literacy Universal Precautions Toolkit. (Prepared by North Carolina Network Consortium, The Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill, under Contract No. HHS290200710014.) AHRQ Publication No. 10-0046-EF) Rockville, MD. Agency for Healthcare Research and Quality. April 2010.
16. Strategies for Improving Minority Healthcare Quality, Structured Abstract. January 2004 Agency for Healthcare Research and Quality, Rockville, MD. Available at: <http://www.ahrq.gov/clinic/tp/minqualtp.htm>.

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

Selected individual studies (rather than entire body of evidence)

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

Studies focus on the domains of the CAHPS Cultural Competence Item Set and their relationship to health and health care. Several studies used the CAHPS Cultural Competence Item Set to establish these relationships.

1c.5 Quantity of Studies in the Body of Evidence (*Total number of studies, not articles*): 15 studies are referenced above, plus one systematic review that contains 64 studies of cultural competence training. These are exemplary and don't represent the full body of evidence.

- 1c.6 Quality of Body of Evidence** (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*): While the field testing of the CAHPS Cultural Competence Item Set is limited to a few sites, the studies have used rigorous psychometric methods. Although response rates were low, there did not appear to be any non-response bias. These studies are bolstered by an array of studies that have examined the same constructs with multiple populations in multiple locations. In the evidence review of cultural competence training the lack of consistency in intervention methods and measured outcomes limited the evidence synthesis. Although there were 20 randomized controlled trials, the randomization was considered adequate (in that investigators could not predict assignment) in only 11 studies. Although there were seven concurrent controlled trials, there was one study in which the comparison group was considered inadequate (dissimilar).
- 1c.7 Consistency of Results across Studies** (*Summarize the consistency of the magnitude and direction of the effect*): The domains measured in the CAHPS Cultural Competence Item Set to be related to access, adherence, satisfaction, and other health outcomes.
- 1c.8 Net Benefit** (*Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms*):
Not applicable
- 1c.9 Grading of Strength/Quality of the Body of Evidence.** Has the body of evidence been graded? Yes
- 1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:** Johns Hopkins University Evidence-based Practice Center
- 1c.11 System Used for Grading the Body of Evidence:** Other
- 1c.12 If other, identify and describe the grading scale with definitions:** AHRQ Evidence-based Practice Center grading methods.
- 1c.13 Grade Assigned to the Body of Evidence:** Excellent evidence for improvement in provider knowledge, good evidence for improvement in provider attitudes and skills, and good evidence for improvement in patient satisfaction.
- 1c.14 Summary of Controversy/Contradictory Evidence:** none identified
- 1c.15 Citations for Evidence other than Guidelines**(*Guidelines addressed below*):
1. Thom DH, Kravitz RL, Bell RA, et al. Patient trust in the physician: relationship to patient requests. *Family Practice* 2002;19:476-483
 2. Hunt KA, Gaba A, Lavizzo-Mourey R. Racial and ethnic disparities and perceptions of health care: does health plan type matter? *Health Services Research* 2005;40:551-576
 3. Schnittker J. Social distance in the clinical encounter: interactional and sociodemographic foundations for mistrust in physicians. *Social Psychology Quarterly* 2004;67:217-235
 4. Meredith LS, Siu AL. Variation and quality of self-report health data: Asians and Pacific Islanders compared with other ethnic groups. *Medical Care* 1995;1120-1131
 5. LaVeist TA, Nickerson KJ, Bowie JV. Attitudes about racism, medical mistrust, and satisfaction with care among African American and white cardiac patients. *Medical Care Research and Review* 2000;57:146-161
 6. Fernandez A, Seligman H, Quan J, Stern RJ, Jacobs EA. Associations between Aspects of Culturally Competent Care and Diabetes Outcomes among Ethnically Diverse Patients with Diabetes. *Medical Care* (under review).
 7. Slean GR, Jacobs EA, Lahiff M, Fisher L, PhD4, Fernandez F. Diabetes Distress is Associated with Reports of Suboptimal Culturally Competent Care. *Medical Care* (under review).
 8. Bird ST, Bogart LM, Delahanty DL. Health-related correlates of perceived discrimination in HIV care. *AIDS patient care and STDs* 2004;18:19-26
 9. Crowe M, Sartori A, Clay OJ, et al. Diabetes and cognitive decline: investigating the potential influence of factors related to health disparities. *Journal of aging and health* 2010;22:292-306

10. Benkert R, Peters RM, Clark R, et al. Effects of perceived racism, cultural mistrust and trust in providers on satisfaction with care. *Journal of the National Medical Association* 2006;98:1532-1540
11. Sorkin DH, Ngo-Metzger Q, De Alba I. Racial/ethnic discrimination in health care: impact on perceived quality of care. *Journal of General Internal Medicine* 2010;25:390-396
12. Hausmann LRM, Hannon MJ, Kresevic DM, et al. Impact of Perceived Discrimination in Healthcare on Patient-Provider Communication. *Medical Care* 2011;49:626-633
13. Weech-Maldonado, Hall A, Bryant T, Jenkins KA, Elliott MN. Does Perceived Discrimination Affect Patient Experiences with Health Care? *Medical Care* (under review).
14. Fortier J. P., Bishop, D. 2004. Setting the agenda for research on cultural competence in health care: final report. Edited by C. Brach. Rockville, MD: U.S. Department of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality.
15. DeWalt DA, Callahan LF, Hawk VH, Brouckson KA, Hink A, Rudd R, Brach C. Health Literacy Universal Precautions Toolkit. (Prepared by North Carolina Network Consortium, The Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill, under Contract No. HHS290200710014.) AHRQ Publication No. 10-0046-EF) Rockville, MD. Agency for Healthcare Research and Quality. April 2010.
16. Strategies for Improving Minority Healthcare Quality, Structured Abstract. January 2004 Agency for Healthcare Research and Quality, Rockville, MD. Available at: <http://www.ahrq.gov/clinic/tp/minqualtp.htm>

1c.16 Quote verbatim, the specific guideline recommendation (Including guideline # and/or page #):
not applicable

1c.17 Clinical Practice Guideline Citation: not applicable

1c.18 National Guideline Clearinghouse or other URL: not applicable

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

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

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

1c.22 If other, identify and describe the grading scale with definitions: not applicable

1c.23 Grade Assigned to the Recommendation: not applicable

1c.24 Rationale for Using this Guideline Over Others: not applicable

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

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

Was the threshold criterion, *Importance to Measure and Report*, met?
(1a & 1b must be rated moderate or high and 1c yes) Yes No

Provide rationale based on specific subcriteria:

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

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

2. RELIABILITY & VALIDITY - SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the

appropriate field. Supplemental materials may be referenced or attached in item 2.1. See [guidance on measure testing](#).

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

S.2 If yes, provide web page URL: <https://www.cahps.ahrq.gov/Surveys-Guidance/Item-Sets/Cultural-Competence.aspx>

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

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

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

We recommend that the Clinicians/Groups' Health Literacy Practices measures be calculated using the top box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses.

Two composites can be calculated from the item set: 1) Providers are caring and inspire trust (5 items), and 2) Providers are polite and considerate (3 items).

2a1.2 Numerator Time Window (*The time period in which the target process, condition, event, or outcome is eligible for inclusion*):
Last 12 months

2a1.3 Numerator Details (*All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, codes with descriptors, and/or specific data collection items/responses*):
Top Box Method: Calculate the number of responses in the most positive response category for each item. Below each item is listed with the most positive response indicated in parentheses.

Note that for CU1, CU2, CU3, CU4, CU5, CU14, and CU15, the most positive response is "Never." Specific instructions for how reverse coding can be done in SAS can be found in "Instructions for Analyzing CAHPS Data" (available at: https://www.cahps.ahrq.gov/Surveys-Guidance/Dental/-/media/Files/SurveyDocuments/Dental/Prep_Analyze/2015_instructions_for_analyzing_data.pdf) in the section called "Data Set Specification."

CU1 In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English? (Never)

CU2 In the last 12 months, how often did this provider use medical words you did not understand? (Never)

CU3 In the last 12 months, how often did this provider talk too fast when talking with you? (Never)

CU4 In the last 12 months, how often did this provider ignore what you told him or her? (Never)

CU5 In the last 12 months, how often did this provider interrupt you when you were talking? (Never)

CU6 In the last 12 months, how often did this provider show interest in your questions and concerns? (Always)

CU7 In the last 12 months, how often did this provider answer all your questions to your satisfaction? (Always)

CU8 In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Never)

CU11 In the last 12 months, has this provider ever asked you if you have used an acupuncturist or an herbalist to help with an illness or to stay healthy? (Yes)

- CU13 In the last 12 months, has this provider ever asked you if you used natural herbs? (Yes)
- CU14 In the last 12 months, how often have you been treated unfairly at this provider's office because of your race or ethnicity? (Never)
- CU15 In the last 12 months, how often have you been treated unfairly at this provider's office because of the type of health insurance you have or because you don't have health insurance? (Never)
- CU16 In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else? Yes, definitely
- CU17 In the last 12 months, did you feel you could trust this provider with your medical care? (Yes, definitely)
- CU18 In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news? (Yes, definitely)
- CU19 In the last 12 months, did you feel this provider cared as much as you do about your health? (Yes, definitely)
- CU20 In the last 12 months, did you feel this provider really cared about you as a person? (Yes, definitely)
- CU21 Using any number from 0 to 10, where 0 means that you do not trust this provider at all and 10 means that you trust this provider completely, what number would you use to rate how much you trust this provider? (9-10)
- CU23 An interpreter is someone who helps you talk with others who do not speak your language. Interpreters can include staff from the doctor's office or telephone interpreters. In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge? (Yes)
- CU25 In the last 12 months, when you needed an interpreter to help you speak with doctors or other health providers, how often did you get one? (Always)
- CU28 In the last 12 months, how often did this interpreter treat you with courtesy and respect? (Always)
- CU29 Using any number from 0 to 10, where 0 is the worst interpreter possible and 10 is the best interpreter possible, what number would you use to rate this interpreter? (9-10)
- CU31 Did any of your appointments start late because you had to wait for an interpreter? (No)
- CU33 In the last 12 months, did you use friends or family members as interpreters because that was what you preferred? (Yes)

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

Adults with a visit to the provider for which the survey is being fielded within the last 12 months who responded to the item.

2a1.5 Target Population Category (Check all the populations for which the measure is specified and tested if any): Adult/Elderly Care

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

Last 12 months

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

The denominator is the total number of respondents who selected a response option to a particular item. Respondents may have not answered an item because of a screener that skipped them over that item, or because they chose to skip that question.

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

Exclusions are made when sample is drawn from provider records. Only patients 18 or older and those who have had a visit with a

provider in the last 12 months are sampled. Core question 4 verifies that the respondent got care from the provider in the last 12 months.

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

Exclusions are made when sample is drawn from provider records. Only patients 18 or older and those who have had a visit with a provider in the last 12 months are sampled. Core question 4 verifies that the respondent got care from the provider in the last 12 months.

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

Stratification by race and ethnicity can be done using the following Core items:

31: Are you of Hispanic or Latino origin or descent?

32: What is your race? Mark one or more.

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

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

not applicable

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

2a1.17-18. Type of Score: Non-weighted score/composite/scale

2a1.19 Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score): Better quality = Higher score

2a1.20 Calculation Algorithm/Measure Logic(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.):

Composites can be calculated for an individual provider (e.g., a doctor), or for a practice or clinic.

The Providers Are Caring and Inspire Trust Composite consists of 5 items in the composite:

CU16. In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else? (Response: Never/Sometimes/Usually/Always)

CU17. In the last 12 months, did you feel you could trust this provider with your medical care? (Response: N/S/U/A)

CU18. In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news? (Response: N/S/U/A)

CU19. In the last 12 months, did you feel this provider cared as much as you do about your health? (Response: N/S/U/A)

CU20. In the last 12 months, did you feel this provider really cared about you as a person? (Response: N/S/U/A)

The Providers Are Polite and Considerate Composite consists of 3 items:

CU3. In the last 12 months, how often did this provider talk too fast when talking with you? (Response: N/S/U/A)

CU8. In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Response: N/S/U/A)

CU5. In the last 12 months, how often did this provider interrupt you when you were talking? (Response: N/S/U/A)

To calculate the Providers Are Caring and Inspire Trust Composite:

STEP1: Calculate the proportion of respondents in each response category for each item in the composite (i.e., the number of respondents who gave the response divided by the total number of respondents who answered that item). Start by calculating for CU16:

- The proportion of respondents who answered "never"
- The proportion of respondents who answered "sometimes"
- The proportion of respondents who answered "usually"
- The proportion of respondent who answered "always"

Follow this step for CU17, CU18, CU19, and CU20.

STEP 2: Calculate the average proportion responding to each category across the questions in the composite. For example, to calculate the composite for those who answered "always," calculate:

(Proportion of respondents who answered "always" to CU16 + Proportion of respondents who answered "always" to CU17 + Proportion of respondents who answered "always" to CU18 + Proportion of respondents who answered "always" to CU19 + Proportion of respondents who answered "always" to CU20)/5

Repeat STEP 2 for the proportion of respondents who answered "usually," the proportion of respondents who answered "sometimes," and the proportion of respondents who answered "never."

The Communication about Medicines Composite is calculated in the same way, except that – because there are only 3 items in the composite, the denominator in the calculation of the average proportion responding to each category should be divided by 3.

Additional detail on the algorithm to calculate these composites is available from the CAHPS® Clinician & Group Surveys Instructions for Patient Experience Measures. Instructions for analyzing composite measures in SAS are available in the CAHPS Clinician & Group Surveys and Instructions, Instructions for Analyzing Data. Both are available at: <https://www.cahps.ahrq.gov/Surveys-Guidance/CG/Get-CG-Surveys-and-Instructions.aspx>.

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

URL

<https://www.cahps.ahrq.gov/Surveys-Guidance/CG/Get-Surveys-and-Instructions.aspx>

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

Details on sampling methodology can be found at https://www.cahps.ahrq.gov/Surveys-Guidance/CG/-/media/Files/SurveyDocuments/CG/12%20Month/Admin_Survey/1033_CG_Fielding_the_Survey.pdf

Data Source: The source of sample information will vary by survey sponsor. The decision will depend on which organization has the most accurate and complete data. Health plans or purchasers of care may have administrative or billing data to identify individual patients. In some instances, the data to identify individual patients may be found only in the records of medical practices. It may be necessary to pull data from two or more sources in order to have both up-to-date contact information and to be able to connect the visit to a specific provider.

Number Completes and Response Rates: 45 completed surveys per provider is recommended for measures of individual providers. 300 completed surveys are recommended for large entities such as multi-site medical practices. Surveys can be administered by mail, by phone, or mail with phone follow-up. Response rates of at least 40% are recommended.

Administration Mode. The CAHPS Surgical Care Survey may be administered by one of the following modes as each has been found to provide comparable results:

- Mail only: Three-wave mail protocol: complete survey and letter, postcard reminder (10 days later), complete survey (3

weeks later).

- Telephone only: At least 6 attempts on different days (weekdays and weekends), at different times of the day, and in different weeks.
- Mail with telephone follow up: mail protocol followed by telephone protocol 3 weeks after sending the second questionnaire.

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

2a1.26 **Data Source/Data Collection Instrument** (Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.): CAHPS Cultural Competence Item Set

2a1.27-29 **Data Source/data Collection Instrument Reference Web Page URL or Attachment:** Attachment CAHPS Cultural Competence Item Set 1-31-12 revised.docx

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

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

2a1.34-35 **Care Setting** (Check all the settings for which the measure is specified and tested): Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office

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

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

The CAHPS Cultural Competence Item Set field test was conducted with a stratified random sample of 6,000 adult (18 years and older) enrollees of two Medicaid managed care plans, one in New York (3,200) and the other in California (2,800) in 2008. We chose Medicaid plans in New York and California as the states for the field test given the diversity of their population. The sample was stratified based on race/ethnicity and language: 1,200 White English speakers, 1,200 Black English speakers, 900 Hispanic English speakers, 900 Hispanic Spanish speakers, 900 Asian English speakers, and 900 Asian non-English speakers. Health plan enrollees 65 years and older were not included in the sample, since health care experiences of the dually eligible population may be different than those with Medicaid as their primary insurer. While only 26% response rate (n=1,380) was achieved, there were no significant differences between respondents and non-respondents in terms of gender, Hispanic or Asian ethnicity, primary language, or health plan affiliation. After excluding individuals that did not have a personal doctor or a doctor visit during the last 12 months, the final analytic sample consisted of 991 respondents.

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

First, exploratory factor analysis (EFA) in both SAS and Mplus and confirmatory factor analysis (CFA) in Mplus were conducted. Factor analyses using Mplus accounted for the ordinal nature of the response options. Second, multitrait scaling analysis was used to assess item discrimination across scales.

Third, we used Cronbach's alpha to estimate scale internal consistency reliability. Cronbach alphas were estimated for the overall sample. Fourth, a bi-factor analysis was used to explore whether a multidimensional model or unidimensional (bi-factor) model best represented the measurement structure of the data. A multidimensional factor structure consists of meaningful and separate factors, while a bi-factor model consists of a single dimension (the general factor) accompanied by "specific," "nuisance," or "group" factors. Group factors can result from patterns in survey questions, such as common content (e.g., repeated questions about a similar topic) or common methodology (e.g., questions with similar stems). If the bifactor model fits better than the multidimensional model, one would generally choose the bifactor model over the multidimensional model.

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

We tested each of 8 domains of the item set for internal consistence reliability to see if they would support a composite measure. Cronbach alphas are listed below for each hypothesized composite.

Doctor Communication-Positive Behaviors
(5 items using communication items from the Clinician/Group CAHPS Core) Alpha= 0.92

Doctor Communication-Negative Behaviors
(4 items: CU3, CU4, CU5, and CU8) Alpha=0.71

Doctor Communication-Health Promotion
(3 items that were subsequently removed from the item set) Alpha=0.76

Doctor Communication-Alternative Medicine
(2 items: CU11 and CU13) Alpha=0.58

Shared Decision Making
(2 items that subsequently removed from the item set) Alpha=0.69

Equitable Treatment
(2 items: CU14 and CU15) Alpha=0.64

Trust
(5 items: CU16, CU17, CU18, CU19 and CU20) Alpha=0.89

Access to Interpreter Services
(CU28, CU31 and 2 other items dropped from the item set) Alpha=0.67

Four of the hypothesized composites demonstrated sufficient reliability. Of those four, two were discarded: Doctor-Communication-Positive Behaviors largely overlapped with the existing CAHPS Communication Composite, and the items supporting the Doctor Communication-Health Promotion Composite were removed from the item set. These items appear in another CAHPS supplemental item set and it was decided to cross-reference these items and note that they could be stratified by race/ethnicity. The remaining two composites were renamed. Doctor Communication-Negative Behaviors became the Providers are Polite and Considerate Composite (scored with "Never" being the most positive response) and Trust became the Providers are Caring and Inspire Trust Composite.

Full results are in Weech-Maldonado R, Carle A, Weidmer, B, Hurtado M, Ngo-Metzger Q, Hays RD. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cultural Competence (CC) Item Set. Medical Care (under review).

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

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

We conducted cognitive testing to determine that patients were able to understand and answer the items. Cognitive testing identifies items that have face validity but are interpreted differently than anticipated. Cognitive testing confirms that the item is indeed measuring what it is purported to measure.

Correlations with global rating of providers allowed us to determine that these items were related to patient satisfaction. Regression analyses were conducted to examine the associations between the CAHPS CC composite scores and the overall doctor rating item, controlling for race/ethnicity, gender, age, education, self-rated health status, and language of the survey (Spanish vs. English). Separate regression models were run for each composite. The CAHPS global rating (0-10) for personal doctor, where 0= worst possible doctor and 10= best possible doctor, was linearly transformed to a 0-100 possible range (i.e., multiplied by 10). The composite scores were calculated in a two-step process: adding the items within composite, and then linearly transforming the total to a 0-100 possible range.

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

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

Cognitive testing: English and Spanish-speaking individuals of diverse race/ethnicity and education levels.

Correlations: same field test sample describe in 2.a.1.

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

Methods to determine validity included cognitive testing, and calculating correlations with a global measure of the provider (i.e., rating the provider on a scale of 1 to 10).

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

Cognitive testing were used to detect and minimize some sources of measurement error by identifying question items or terms that are difficult to comprehend, questions that are misinterpreted by the respondents, and response options that are inappropriate for the question or that fail to capture a respondent's experience.

For the Providers are Polite and Considerate Composite, the coefficient for the regression onto the overall doctor rating was .67 ($p < 0.001$). For the Providers are Caring and Inspire Trust Composite, the coefficient for the regression onto the overall doctor rating was .6 ($p < 0.001$).

Full results are in Weech-Maldonado R, Carle A, Weidmer, B, Hurtado M, Ngo-Metzger Q, Hays RD. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cultural Competence (CC) Item Set. Medical Care (under review).

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

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

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

No exclusions beyond numerator and denominator exclusions.

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

See sections on Numerator and Denominator Specifications.

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

not applicable

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

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

Not applicable. No mode of survey adjustment or other adjustment was made.

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

not applicable

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

not applicable

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: Testing was to determine how measures performed rather than to get reportable scores. Furthermore, case mix adjusters commonly used with CAHPS (i.e., age, education) are correlated with limited health literacy, which is correlated with race and ethnicity. The items are designed to measure how well providers communicate with all their patients, including those with limited health literacy. It is not desirable to adjust for these factors.

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

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

Not available.

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

Not available.

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

Not available.

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

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

Not available.

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

Not available.

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

Not available.

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

2c.1 If measure is stratified for disparities, provide stratified results *(Scores by stratified categories/cohorts):* For analyses of discrimination items, race/ethnicity was an independent variable in regression analysis rather than using for stratification.

Respondents who were Black had higher odds of reporting discrimination based on race/ethnicity than White respondents.(15) Another analysis found that African-Americans and Latinos were less likely than Whites to report poor cultural competency as measured by the CAHPS Cultural Competence Item Set. The authors posit this is because all of the patients were recruited from the safety-net setting. Many more of the White patients seeking care in these settings are homeless, use illicit substances, or have ongoing psychiatric illness than Latino and African-American patients. It may be that White patients experience less culturally competent care not because of their race but because of these other co-morbidities, although further research will be needed to fully understand why Whites report less culturally competent care in this setting.

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

Not applicable

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?

(Reliability and Validity must be rated moderate or high) Yes No

Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

3. USABILITY

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

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

3.1 Current Use (Check all that apply; for any that are checked, provide the specific program information in the following questions): [Use unknown](#)

3a. Usefulness for Public Reporting: H M L I

(The measure is meaningful, understandable and useful for public reporting.)

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

[The CAHPS Cultural Competence measures are not currently used for public reporting.](#)

3a.2. Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results:

[Stakeholders who are the targeted consumers of public reports provided input into the development of the measures. In addition, these items are similar to CAHPS items that are currently used for consumer health plan decision making. For example, the Federal government makes CAHPS scores available for the health plans offered to employees.](#)

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s): [Programs to accredit patient-centered medical homes \(e.g., Joint Commission, NCQA\) increasingly call for providers to be culturally competence. The CAHPS Cultural Competence Item Set could be used as a means of verifying that those standards are being met.](#)

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

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

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

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

[The use of the CAHPS Cultural Competence measures for quality improvement is unknown. However, the forthcoming "National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Practice and Policy" lists the measures as a resource for Standard 9: Assess CLAS and Integrate CLAS Measures. This is expected to stimulate use of the measures.](#)

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

[Often providers are unaware of patient's perceptions of discrimination, distrust, availability of language services, or poor communication. These measures can help providers learn what their opportunities for improvement are, and to measure whether there have been any changes in patient experiences after improvement initiatives have been undertaken.](#)

Overall, to what extent was the criterion, *Usability*, met? H M L I

Provide rationale based on specific subcriteria:

4. FEASIBILITY

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

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

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

Data used in the measure are:

Other

Fielding CAHPS Cultural Competence Item Set

4b. Electronic Sources: H M L I

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

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources: Surveys could be administered through a Web portal that would calculate scores automatically. For example, items could be put on Survey Monkey. However, respondents would be restricted to those who had access to the Internet and skills to navigate the survey online. This would like bias the sample unless there was mail and/or phone follow-up.

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

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

Errors can occur when coding. Instructions, for cleaning and analysis can be found in the Instructions for Analyzing Data from CAHPS Surveys, available at: https://www.cahps.ahrq.gov/Surveys-Guidance/Dental/~media/Files/SurveyDocuments/Dental/Prep_Analyze/2015_instructions_for_analyzing_data.pdf

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

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

4d.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues (e.g., fees for use of proprietary measures):

As has been observed in other studies, achieving a high response rate among Medicaid beneficiaries is extremely difficult. Despite a multi-prong effort (2 mailings, an 800 number to request a copy of the survey materials in Spanish, telephone follow ups in English and Spanish and an incentive of \$10 was offered to non-respondents after the second call attempt) the response rate on reached 26%.

Overall, to what extent was the criterion, *Feasibility*, met? H M L I

Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

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

Rationale:

If the Committee votes No, STOP.

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

5. COMPARISON TO RELATED AND COMPETING MEASURES

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the

same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure before a final recommendation is made.

5.1 If there are related measures (*either same measure focus or target population*) or competing measures (*both the same measure focus and same target population*), list the NQF # and title of all related and/or competing measures:
 0005 : CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as [NQF-endorsed measure\(s\)](#): Are the measure specifications completely harmonized? **Yes**

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

5b. Competing Measure(s)

5b.1 If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures (*e.g., a more valid or efficient way to measure quality*); OR provide a rationale for the additive value of endorsing an additional measure. (*Provide analyses when possible*):
 Not applicable.

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): [Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, Maryland, 20850](#)

Co.2 Point of Contact: [Cindy, Brach, cindy.brach@ahrq.hhs.gov, 301-427-1444-](#)

Co.3 Measure Developer if different from Measure Steward: [Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, Maryland, 20850](#)

Co.4 Point of Contact: [Cindy, Brach, cindy.brach@ahrq.hhs.gov, 301-427-1444-](#)

Co.5 Submitter: [Cindy, Brach, cindy.brach@ahrq.hhs.gov, 301-427-1444-](#), [Agency for Healthcare Research and Quality](#)

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

Co.7 Public Contact: [Cindy, Brach, cindy.brach@ahrq.hhs.gov, 301-427-1444-](#), [Agency for Healthcare Research and Quality](#)

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development

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

The members of the survey development team were:

- [Adam Carle - University of Cincinnati](#)
- [Charles Darby - AHRQ](#)
- [Robert Weech-Maldonado - University of Alabama](#)
- [Beverly Weidmer - RAND](#)
- [Margarita Hurtado - Hurtado](#)
- [Ouyen Ngo-Metzger - Health Resources and Services Administration](#)
- [Ron D. Hays - RAND](#)

Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for

adapting the original measure and any work with the original measure steward:
Measure Developer/Steward Updates and Ongoing Maintenance Ad.3 Year the measure was first released: 2011 Ad.4 Month and Year of most recent revision: 01, 2012 Ad.5 What is your frequency for review/update of this measure? Ad.6 When is the next scheduled review/update for this measure?
Ad.7 Copyright statement:
Ad.8 Disclaimers:
Ad.9 Additional Information/Comments:
Date of Submission (MM/DD/YY): 01/18/2012

CAHPS Cultural Competence Item Set 1-31-12

Core 1. Our records show that you got care from the provider named below in the last 12 months.

Name of provider label goes here

Is that right?

¹ Yes

² No → **If No, go to Core #26**

CU1. In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English?

¹ Never

² Sometimes

³ Usually

⁴ Always

CU2. In the last 12 months, how often did this provider use medical words you did not understand?

¹ Never

² Sometimes

³ Usually

⁴ Always

CU3. In the last 12 months, how often did this provider talk too fast when talking with you?

¹ Never

² Sometimes

³ Usually

⁴ Always

CU4. In the last 12 months, how often did this provider ignore what you told him or her?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

CU5. In the last 12 months, how often did this provider interrupt you when you were talking?

- ⁴ Never
- ³ Sometimes
- ² Usually
- ¹ Always

CU6. In the last 12 months, how often did this provider show interest in your questions and concerns?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

CU7. In the last 12 months, how often did this provider answer all your questions to your satisfaction?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

CU8. In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

CU9. People sometimes see someone else besides their providers or specialists to help with an illness or to stay healthy. In the last 12 months, have you ever used an acupuncturist?

- ¹ Yes

² No

CU10. In the last 12 months, have you ever used an herbalist?

¹ Yes

² No

CU11. In the last 12 months, has this provider ever asked you if you have used an acupuncturist or an herbalist to help with an illness or to stay healthy?

¹ Yes

² No

CU12. Some people use natural herbs for health reasons or to stay healthy. Natural herbs include things such as ginseng, green tea, and other herbs. People can take them as a pill, a tea, oil, or a powder.

In the last 12 months, have you ever used natural herbs for your own health?

¹ Yes

² No

CU13. In the last 12 months, has this provider ever asked you if you used natural herbs?

¹ Yes

² No

CU14. In the last 12 months, how often have you been treated unfairly at this provider's office because of your race or ethnicity?

¹ Never

² Sometimes

³ Usually

⁴ Always

CU15. In the last 12 months, how often have you been treated unfairly at this provider's office because of the type of health insurance you have or because you don't have health insurance?

¹ Never

² Sometimes

³ Usually

⁴ Always

CU16. In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else?

- ¹ Yes, definitely
- ² Yes, somewhat
- ³ No

CU17. In the last 12 months, did you feel you could trust this provider with your medical care?

- ¹ Yes, definitely
- ² Yes, somewhat
- ³ No

CU18. In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news?

- ¹ Yes, definitely
- ² Yes, somewhat
- ³ No

CU19. In the last 12 months, did you feel this provider cared as much as you do about your health?

- ¹ Yes, definitely
- ² Yes, somewhat
- ³ No

CU20. In the last 12 months, did you feel this provider really cared about you as a person?

- ¹ Yes, definitely
- ² Yes, somewhat
- ³ No

CU21. Using any number from 0 to 10, where 0 means that you do not trust this provider at all and 10 means that you trust this provider completely, what number would you use to rate how much you trust this provider?

- 0 Do not trust this provider at all
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Trust this provider completely

CU22. What is your preferred language? <specify relevant languages>

- English → **If English, go to Core #24**
- LANGUAGE 1
- LANGUAGE 2
- LANGUAGE 3
- LANGUAGE 4
- LANGUAGE 5
- LANGUAGE 6
- LANGUAGE 7
- LANGUAGE 8
- LANGUAGE 9
- Some other language

CU23. An interpreter is someone who helps you talk with others who do not speak your language. Interpreters can include staff from the doctor's office or telephone interpreters. In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge?

- ¹ Yes
- ² No

CU24. In the last 12 months, was there any time when you needed an interpreter at this doctor's office?

- ¹ Yes
- ² No → **If Never, go to Core #24**

CU25. In the last 12 months, when you needed an interpreter to help you speak with doctors or other health providers, how often did you get one?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

CU26. In the last 12 months, how often did you use an interpreter provided by this office to help you talk with this provider?

- ¹ Never → **If Never, go to CU32**
- ² Sometimes
- ³ Usually
- ⁴ Always

CU27. In the last 12 months, when you used an interpreter provided by this office who was the interpreter you used most often?

- A nurse, clerk, or receptionist from this office
- An interpreter provided in-person by this office
- A telephone interpreter provided by this office
- Someone else provided by this office

CU28. In the last 12 months, how often did this interpreter treat you with courtesy and respect?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

CU29. Using any number from 0 to 10, where 0 is the worst interpreter possible and 10 is the best interpreter possible, what number would you use to rate this interpreter?

- 0 Worst interpreter possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Best interpreter possible

CU30. In the last 12 months, did any of your appointments with this provider start late?

- ¹ Yes
- ² No

CU31. Did any of your appointments start late because you had to wait for an interpreter?

- ¹ Yes
- ² No

CU32. In the last 12 months, how often did you use a friend or family member as an interpreter when you talked with this doctor?

- ¹ Never→ **If Never, go to Core #24**
- ² Sometimes
- ³ Usually
- ⁴ Always

CU33. In the last 12 months, did you use friends or family members as interpreters because that was what you preferred?

- ¹ Yes
- ² No

Core 26. In general, how would you rate your overall health?

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

Core 27. In general, how would you rate your overall **mental or emotional** health?

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

Core 28. What is your age?

- 1 18 to 24
- 2 25 to 34
- 3 35 to 44
- 4 45 to 54
- 5 55 to 64
- 6 65 to 74
- 7 75 or older

Core 29. Are you male or female?

- 1 Male
- 2 Female

Core 30. What is the highest grade or level of school that you have completed?

- 1 8th grade or less
- 2 Some high school, but did not graduate
- 3 High school graduate or GED
- 4 Some college or 2-year degree
- 5 4-year college graduate
- 6 More than 4-year college degree

Core 31. Are you of Hispanic or Latino origin or descent?

- ¹ Yes, Hispanic or Latino
- ² No, not Hispanic or Latino

Core 32. What is your race? Mark one or more.

- ¹ White
- ² Black or African American
- ³ Asian
- ⁴ Native Hawaiian or Other Pacific Islander
- ⁵ American Indian or Alaska Native
- ⁶ Other

Core 33. Did someone help you complete this survey?

- ¹ Yes
- ² No → **Thank you.**

Please return the completed survey in the postage-paid envelope.

Core 34. How did that person help you? Mark one or more.

- ¹ Read the questions to me
- ² Wrote down the answers I gave
- ³ Answered the questions for me
- ⁴ Translated the questions into my language
- ⁵ Helped in some other way

Please print: _____

