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 #: 1902   **NQF Project:** Healthcare Disparities Project
(for Endorsement Maintenance Review) Original Endorsement Date: Most Recent Endorsement Date:

BRIEF MEASURE INFORMATION
De.1 Measure Title: Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
Co.1.1 Measure Steward: Agency for Healthcare Research and Quality
De.2 Brief Description of Measure: These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician & Group Survey. The item set includes the following domains: Communication with Provider (Doctor), Disease Self-Management, Communication about Medicines, Communication about Test Results, and Communication about Forms. Samples for the survey are drawn from adults who have had 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) Communication to improve health literacy (5 items), and 2) Communication about medicines (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) Communication to improve health literacy (5 items), and 2) Communication about medicines (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☐   No☐   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 endorsed **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, Safety : Medication Safety

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, particularly those from minority groups and with limited English proficience.(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. Ratzan SC, Parker RM. Introduction. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services2000. Report No.: NLM Pub. No. CBM 200-1.

2.		Kutner M, Greenberg E, Jin Y, Paulsen C. The health literacy of America´s adults: results from the 2003 National Assessment of Adult Literacy. Washington DC: National Center for Educational Statistics; 2006.

3.		U. S. Department of Health and Human Services. America´s health literacy: why we need accessible health information. Rockville, MD: U. S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion2009.

4.		U.S. Department of Health and Human Services. Communicating health: priorities and strategies for progress. Washington DC2003 July.

5.		Baker DW. The meaning and the measure of health literacy. J Gen Intern Med. 2006 Aug;21(8):878-83.

6.		Parker R, Ratzan SC. Health literacy: a second decade of distinction for Americans. Journal of health communication. [Historical Article]. 2010;15 Suppl 2:20-33.

7.		Koh H, Berwick D, Clancy C, Baur C, Brach C, Harris L, Zerhusen E. New federal policy initiatives to boost health literacy can help the nation move beyond the cycle of costly 'crisis care.' Health Affairs. 2012. 31(2): epublished before print.

8.		U.S. Department of Health and Human Services. Healthy people 2010: understanding and improving health. 2nd ed: U.S. Government Printing Office; 2000.

9.		Adams K, Corrigan JM. Priority areas for national action: transforming health care quality. Washington DC: The National Academies Press2003.

10.		Weiss BD. Health literacy: a manual for clinicians. Chicago: American Medical Association Foundation and American Medical Association; 2003.

11.		Institute of Medicine. Health literacy: a prescription to end confusion. Washington, DC: The National Academies Press; 2004.

12.		Berkman ND, DeWalt DA, Pignone MP, Sheridan SL, Lohr KN, Lux L, et al. Literacy and health outcomes. Rockville, MD: Agency for Healthcare Research and Quality; 2004.

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:
The Item Set for Addressing Health Literacy was developed to provide health care providers with data that could help them improve their health literacy practices. The survey can be used to:
•Identify specific topic areas for quality improvement (e.g., communication about test results, medications, and forms).
•Recognize particular behaviors that inhibit effective communication (e.g., talking too fast, using medical jargon).
•Assist in designing a safer, shame-free environment where patients feel comfortable discussing their health care concerns (e.g., showing interest in questions, explaining forms).
•Measure the effect of behaviors that promote effective communication (e.g., confirming understanding through teach-back, using visual aids).
For example, providers could administer the CAHPS Item Set for Addressing Health Literacy as an assessment tool to identify their health literacy strengths and weaknesses. Having identified opportunities for improvement and embarked on quality improvement activities, the providers could use the Item Set for Addressing Health Literacy again to evaluate the success of its improvement activities.

To assist providers in determining how to address an area needing improvement, the Agency for Healthcare Research and Quality (AHRQ) has mapped each item in the Item Set for Addressing Health Literacy to a health literacy practice recommended by the American Medical Association (AMA) Foundation and the AMA in their 2007 monograph Health Literacy and Patient Safety: Help Patients Understand. This Health Literacy Quality Improvement Crosswalk is available in Appendix B of the About the CAHPS Item Set for Addressing Health Literacy, available at: https://www.cahps.ahrq.gov/Surveys-Guidance/Item-Sets/~/media/Files/SurveyDocuments/CG/12%20Month/Get_Surveys/1311_about_health_lit.pdf. This crosswalk can also identify items to evaluate the implementation of particular AMA recommendations. For specific techniques and strategies to facilitate AMA recommendations, please refer to the monograph at http://www.ama-assn.org/ama1/pub/upload/mm/367/hl_monograph.pdf.

Finally, 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.]
Research indicates that there is substantial room to improve performance across the domains measured by the CAHPS Item Set for Addressing Health Literacy. Almost 8% of patients report that providers sometimes or never explained things in a way they could understand.(1) Patients with limited health literacy report having lower-quality communication with health professionals. They express confusion regarding medical terminology and say that they have insufficient time to express concerns and fail to receive clear explanations.(2-5) The Joint Commission finds that "the safety of patients cannot be assured without mitigating the negative effects of low health literacy and ineffective communications on patient care."(6) Although using techniques to address patients' limited health literacy can improve the quality of health care and health outcomes, clinicians employ them infrequently.(7-8)

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, 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.

2.   Makaryus AN, Friedman EA. Patients' understanding of their treatment plans and diagnosis at discharge. Mayo Clin Proc. 2005;80(8):991–4.

3.   Kripalani S, Jacobson TA, Mugalla IC, Cawthon CR, Niesner KJ, Vaccarino V. Health literacy and the quality of physician-patient communication during hospitalization. J Hosp Med. 2010;5(5):269–75.

4.   Schillinger D, Bindman A, Wang F, Stewart A, Piette J. Functional health literacy and the quality of physician-patient communication among diabetes patients. Patient Educ Couns. 2004;52(3):315–23.

5.   Kripalani S, Henderson LE, Jacobson TA, Vaccarino V. Medication use among inner-city patients after hospital discharge: patient-reported barriers and solutions. Mayo Clin Proc. 2008;83(5):529–35.

6.   Joint Commission. What did the doctor say? Improving health literacy to protect patient safety. Oakbrook Terrace (IL): Joint Commission; 2007. p. 5.

7.   Schillinger D, Piette J, Grumbach K, Wang F, Wilson C, Daher C, et al. Closing the loop: physician communication with diabetic patients who have low health literacy. Arch Intern Med. 2003;163(1):83–90.

8.   Schwartzberg JG, Cowett A, VanGeest J, Wolf MS. Communication techniques for patients with low health literacy: a survey of physicians, nurses, and pharmacists. Am J Health Behav. 2007;31(Suppl 1):S96–104.

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance –Descriptive statistics for performance results for this measure by population group*]
Racial and ethnic disparities in patient reports of provider communication have been documented.The 2010 National Healthcare Disparities Report (NHDR) tracked patient-provider communication from 2002-2007. It found:
•Between 2002 and 2007, the percentage of White, middle-income, and high-income adults who reported poor communication with their health providers significantly decreased.
•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.

The 2010 NHDR also reported on data from the California Health Interview Survey on patients´ understanding of written information from their doctors office. In 2007 Hispanic and non-White patients living in California were less likely than non-Hispanic, White patients to find it easy to understand information from a doctor's office. Also in 2007, patients living in California who did not speak English well or at all were less likely than patients who speak English only or patients who speak English well or very well to find it easy to understand information from a doctor's office. 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 had problems understanding their doctors were

more likely than those who had 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%).

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For <u>Maintenance</u> – 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*]

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.

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.

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☐   <u>If not a health outcome</u>, rate the body of evidence.

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

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	Yes☐
L	M-H	M	Yes☐ IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise **No**☐
M-H	L	M-H	Yes☐ IF potential benefits to patients clearly outweigh potential harms: otherwise **No**☐
L-M-H	L-M-H	L	No ☐

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service	Does the measure pass subcriterion1c? Yes☐ IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship *(Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome)*:

The CAHPS Item Set for Addressing Health Literacy focuses on the clarity of communication between patients and providers. While this is a process measure, patient-provider communication is linked to health outcomes. 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.(1)

Research indicates that providers and groups can adapt how they communicate with patients to improve health care and outcomes, particularly individuals with limited health literacy. For example,
- Medication counseling using a plain language, pictogram-based intervention resulted in fewer medication-dosage errors (5.4 percent versus 47.8 percent) and greater adherence, compared to standard medication counseling (38 percent versus 9.3 percent).(2)
- A study of rates of participation in colon cancer screening compared two groups of providers. One group received feedback on their patients' health literacy status and underwent subsequent training in communicating with patients who had limited literacy skills; the second group did not. The patients of the first group of providers had higher colon cancer screening rates than the patients of the second group of providers (41.3 percent versus 32.4 percent). Among patients with limited literacy, screening rates for patients of providers in the first group were almost twice as high as those for patients of providers in the second group (55.7 percent versus 30 percent).(3)
- A congestive heart failure self-management program—featuring education on self-care, picture-based educational materials, and scheduled telephone follow-up to reinforce adherence to necessary medication regimens and daily weight measurement—reduced hospitalization rates and mortality by 35 percent, compared with patients in the control group.(4)
- Similarly, patients with limited literacy who received a diabetes self-management program that used health literacy strategies were more likely to achieve program goals than people with diabetes who received usual care (42 percent versus 15 percent).(5)

A recent systematic review of the literature concluded that multiple discrete design features improved comprehension, and that

there was consistent, direct, fair or good-quality evidence that intensive self-management interventions that used health literacy strategies reduced emergency department visits and hospitalizations; and intensive self- and disease-management interventions reduced disease severity.(6)

Patients are the best source of information as to whether providers are using evidence-based communication techniques, and whether their communications are understandable. The domains for the item set were developed based on input from stakeholders, obtained through interviews with content experts and through a stakeholder meeting that included representatives from various government agencies, health providers, clinicians, health literacy experts, health literacy advocates, and consumers. In addition, a literature review and environmental scan were conducted in order to identify domains of interest and survey items covering the health literacy domains of interest. A call for measures was issued in the Federal Register to obtain additional measures or surveys that should be considered for inclusion in developing the health literacy item set, however, very few responses were obtained and no additional measures were submitted.

References

1.	DeWalt DA, Callahan LF, Hawk VH, Broucksou KA, Hink A, Rudd R, Brach C. Health Literacy Universal Precautions Toolkit. (Prepared by North Carolina Network Consor¬tium, The Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill, under Contract No. HHSA290200710014.) AHRQ Publication No. 10-0046-EF) Rockville, MD. Agency for Healthcare Research and Quality. April 2010.

2.	Yin HS, Dreyer BP, van Schaick L, Foltin GL, Dinglas C, Mendelsohn AL. Randomized controlled trial of a pictogram-based intervention to reduce liquid medication dosing errors and improve adherence among caregivers of young children. Arch Pediatr Adolesc Med. 2008;162(9):814–22.

3. Ferreira MR, Dolan NC, Fitzgibbon ML, Davis TC, Gorby N, Ladewski L, et al.Health care provider–directed intervention to increase colorectal cancer screening among veterans: results of a randomized controlled trial. J Clin Oncol. 2005;23(7):1548–54.

4. DeWalt DA, Malone RM, Bryant ME, Kosnar MC, Corr KE, Rothman RL, et al.A heart failure self-management program for patients of all literacy levels: a randomized, controlled trial [ISRCTN11535170]. BMC Health Serv Res. 2006;6:30.

5. Rothman RL, DeWalt DA, Malone R, Bryant B, Shintani A, Crigler B, et al.Influence of patient literacy on the effectiveness of a primary care–based diabetes disease management program. JAMA. 2004;292(14):1711–6.

6. Sheridan SL, Halpern DJ, Viera AJ, Berkman ND, Donahue KE, Crotty K. Interventions for individuals with low health literacy: a systematic review. Journal of health communication. 2011 Sep 30;16 Suppl 3:30-54.

1c.2-3 Type of Evidence *(Check all that apply)*:
Selected individual studies (rather than entire body of evidence), Systematic review of body of evidence (other than within guideline development)

1c.4 Directness of Evidence to the Specified Measure *(State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population)*:
Studies showed that provider communication makes a difference to health and health care, and that quality improvement efforts can affect both. The CAHPS Item Set for Addressing Health Literacy measures some of the clinician behaviors associated with better or worse communication. The reports of the CAHPS core communication composite in the NHDR shows that patients can report on communication with their provider, and that these data can be analyzed for disparities.

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)*: The systematic review included 81 studies addressing health outcomes (reported in 95 articles including 86 measuring health literacy and 16 measuring numeracy, of which 7 measure both) and 42 studies (reported in 45 articles) addressing interventions.

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)*: Only good- and fair-quality studies were included in the review.

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect)*: The effects of other mixed interventions on some health outcomes, including knowledge, self-efficacy, adherence, and quality of life, and costs were mixed; thus, the for those outcomes strength of evidence was insufficient.

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: RTI International–University of North Carolina Evidence-based Practice Center Research Triangle Park, North Carolina.

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: Moderate evidence for some types of intervention.

1c.14 Summary of Controversy/Contradictory Evidence: not applicable

1c.15 Citations for Evidence other than Guidelines *(Guidelines addressed below)*:
See references in Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Viera A, Crotty K, Holland A, Brasure M, Lohr KN, Harden E, Tant E, Wallace I, Viswanathan M. Health Literacy Interventions and Outcomes: An Updated Systematic Review. Evidence Report/Technology Assesment No. 199. (Prepared by RTI International–University of North Carolina Evidence-based Practice Center under contract No. 290-2007-10056-I. AHRQ Publication Number 11-E006. Rockville, MD. Agency for Healthcare Research and Quality. March 2011.

1c.16 Quote verbatim, <u>the specific guideline recommendation</u> *(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 <u>developer's assessment</u> 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, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (<u>evaluation criteria</u>)

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 <u>guidance on measure testing</u>.

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 <u>this</u> measure can be obtained? Yes

S.2 If yes, provide web page URL: https://www.cahps.ahrq.gov/Surveys-Guidance/Item-Sets/Health-Literacy.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) Communication to improve health literacy (5 items), and 2) Communication about medicines (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 for the item in parentheses.

Note that for HL1, HL2, HL3, HL5, HL6, and HL17 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."

HL1   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)

HL2   In the last 12 months, how often did this provider use medical words you did not understand?   (Never)

HL3   In the last 12 months, how often did this provider talk too fast when talking with you? (Always)

HL4   In the last 12 months, how often did this provider use pictures, drawings, models, or videos to explain things to you? (Always)

HL5   In the last 12 months, how often did this provider ignore what you told him or her? (Never)

HL6   In the last 12 months, how often did this provider interrupt you when you were talking? (Never)

HL7   In the last 12 months, how often did this provider show interest in your questions and concerns? (Always)

HL8   In the last 12 months, how often did this provider answer all your questions to your satisfaction?   (Always)

HL9   In the last 12 months, how often did this provider give you all the information you wanted about your health? (Always)

HL10   In the last 12 months, how often did this provider encourage you to talk about all your health questions or concerns? (Always)

HL11   In the last 12 months, did you see this provider for a specific illness or for any health condition? [screener for HL 12-17] (NA)

HL12   In the last 12 months, did this provider give you instructions about what to do to take care of this illness or health condition (Yes)

HL13   In the last 12 months, how often were these instructions easy to understand? (Always)

HL14   In the last 12 months, how often did this provider ask you to describe how you were going to follow these instructions? (Always)

HL15   Sometimes providers give instructions that are hard to follow. In the last 12 months, how often did this provider ask you whether you would have any problems doing what you need to do to take care of this illness or health condition? (Always)

HL16   In the last 12 months, how often did this provider explain what to do if this illness or health condition got worse or came back? (Always)

HL17   In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Never)

HL18   In the last 12 months, did this provider prescribe any new medicines or change how much medicine you should take? [screener for HL19-25] (NA)

HL19   In the last 12 months, did this provider give instructions about how to take your medicines? (Yes)

HL20   In the last 12 months, how often were these instructions about how to take you medicines easy to understand?   (Always)

HL21   In the last 12 months, did this provider explain the possible side effects of your medicines? (Yes)

HL22   In the last 12 months, how often were these explanations was easy to understand? (Always)

HL23   In the last 12 months, other than a prescription, did this provider give you written information or write down information about how to take your medicines? (Yes)

HL24   In the last 12 months, how often was the written information you were given easy to understand? (Always)

HL25   In the last 12 months, how often did this provider suggest ways to help you remember to take your medicines? (Always)

Core 21 In the last 12 months, did this provider order a blood test, x-ray, or other test for you? [screener for Core 22] (NA)

Core 22 In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?(NA) [screener for HL26]

HL26   In the last 12 months, how often were the results of your blood test, x-ray, or other test easy to understand? (Always)

HL27   In the last 12 months, did you sign any forms at this provider's office [screener for HL28] (NA)

HL28   In the last 12 months, how often did someone explain the purpose of a form before you signed it? (Always)

HL29   In the last 12 months, did you fill out any forms at this provider's office? [screener for HL30-31]   (NA)

HL30   In the last 12 months, how often were you offered help to fill out a form at this provider's office?   (Always)

HL31   In the last 12 months, how often were the forms from this provider's office easy to fill out? (Always)

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, ethnicity and education can be done using the following Core Items:
30: What is the highest grade or level of school that you have completed? (6 responses)
31: Are you of Hispanic or Latino origin or descent? (2 responses)
32: What is your race? Mark one or more. (6 responses)

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 Communication to Improve Health Literacy Composite consists of 5 items:

HL9. In the last 12 months, how often did this provider give you all the information you wanted about your health? (Response: Never/Sometimes/Usually/Always)

HL10. In the last 12 months, how often did this provider encourage you to talk about all your health problems or concerns? (Response: N/S/U/A)

HL14. In the last 12 months, how often did this doctor ask you to describe how you were going to follow these instructions? (Response: N/S/U/A)

HL20. In the last 12 months, how often were these instructions about how to take you medicines easy to understand? (Response: N/S/U/A)

HL26. In the last 12 months, how often were the results of your blood test, x-ray or other test easy to understand? (Response: N/S/U/A)

The Communication about Medicines Composite consists of 3 items:

HL22. In the last 12 months, how often were these explanations [of possible side effects of your medicines] easy to understand? (Response: N/S/U/A)

HL24. In the last 12 months, how often was the written information you were given easy to understand? (Response: N/S/U/A)

HL25. In the last 12 months, how often did this provider suggest ways to help you remember to take your medicines? (Response: N/S/U/A)

To calculate the Communication to Improve Health Literacy 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 HL9:
• 　　　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 HL10, HL14, HL20, and HL26.

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 HL9 + Proportion of respondents who answered "always" to HL10 + Proportion of respondents who answered "always" to HL14 + Proportion of respondents who answered "always" to HL20 + Proportion of respondents who answered "always" to HL26)/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 Item Set for Health Literacy 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 Item Set for Addressing Health Literacy

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment: Attachment
CAHPS Item Set to Address Health Literacy 1-31-12.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 Item Set for Addressing Health Literacy was field tested at two different sites: a health plan located in The Bronx in New York City that has a large number of minority and Spanish speaking population, and an outpatient clinic that serves a primarily African American population and that is based in an academic medical center in the southern United States. A total of 1200 adult patients were randomly selected from each site (600 from each field test partner). The sample file for the field test was drawn by each of our field test partners according to specifications developed by RAND. Field test sites were instructed to randomly select adults (18 years old or older) with at least one outpatient visit in the prior 12 months. The survey was field tested in both English and Spanish via mail with phone follow up. We obtained a total of 601 completed surveys.

2a2.2 Analytic Method (*Describe method of reliability testing & rationale*):
We examined the correlations within 6 hypothesized composites (patient/provider communication; communication about health problems or concerns; disease self-management; communication about medications; communication about test results; communication about forms).

2a2.3 Testing Results (*Reliability statistics, assessment of adequacy in the context of norms for the test conducted*):
Correlations between items and scales revealed that the data were not very consistent within the hypothesized item clusters. We iteratively revised the placement of items into composites, which resulted only two composites, a 17-item Communication to Improve Health Literacy composite, and a 3-item Communication about Medicines composite. Item-scale correlations ranged from 0.30 to 0.79 for the 17-item Communication to Improve Health Literacy composite and from 0.49 to 0.60 for the 3-item Communication about Medicines composite.
The large number of items included in the Communication to Improve Health Literacy makes it unlikely that users will choose to use it. For this reason, we conducted additional analyses in order to identify a short version of this reporting composite that can still be used to provide a composite score for communication to improve health literacy. We regressed the Communication to Improve Health Literacy scale score on the items on the composites to identify the subset of items that accounted for 90% of the variance in this composite (using the MaxR option in PROC REG). We found that 5 items accounted for 90% of the variance in the longer composite on Communication to Improve Health Literacy. The mean for the 5-item short version of the composite on Communication to Improve Health Literacy was 84 (SD = 21). Internal consistency reliability estimates for this composite was 0.79. Full results are in Weidmer B, Brach C, Hays R. Developing a CAHPS® Item Set For Addressing Health Literacy for Ambulatory Care. Medical Care (under review)

2b. VALIDITY. Validity, Testing, <u>including all Threats to Validity</u>: 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:**
Cognitive testing allowed us to determine that patients were able to understand and answer the items. Correlations with global

rating of providers allowed us to determine that these items were related to patient satisfaction.

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*):
After the first round of interviews, we identified items that were problematic and wording changes that had to be made in both English and Spanish, and reduced the number of items in the item set. We conducted a second round of cognitive interviews in both English and Spanish with the revised item set and used the findings from the second round of testing to further refine the survey items in both languages.

Correlations of each items with the global rating of the provider ranged from 0.42 to 0.61 on individual items. Both composites had significant unique associations with the global rating of the doctor. (6.77, p <.0001for the 5-item Communication to Improve Health Literacy composite and t = 6.77, p <.0001 for the 3-item Communication about Medicines composite).

Full results are in Weidmer B, Brach C, Hays R. Developing a CAHPS® Item Set For Addressing Health Literacy for Ambulatory Care. 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. 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 applicable.

2b6.2 Analytic Method *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure)*:
not applicable.

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 applicable.

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)*: While measures were not stratified by race and ethnicity in field tests, other similar measures have shown racial and ethnic disparities. For example, Non-Hispanic White patients living in California were more likely than all other racial and ethnic groups to find it easy to understand information from a doctor's office. (Source: National Healthcare Disparities Report citing data from the California Health Interview Survey). See 1b.4 for additional data on stratified CAHPS communication measures. Furthermore, there are several potential means by which addressing health literacy could reduce health disparites. (See Saha S. Improving literacy as a means to reducing health disparities. J Gen Intern Med. 2006 Aug;21(8):893-5.

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:
Measures could be stratified by race or ethnicity if there are sufficiently large numbers in each group. Results of field testing were not stratified because we were examining the overall performance of the measures rather than their ability to detect disparities. As noted in 1.b.4, however, racial and ethnic disparities have been observed in other CAHPS measures of communication.

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)*: Public Reporting, Quality Improvement (Internal to the specific organization), 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.*]
Three items from the CAHPS Item Set for Addressing Health Literacy (how often were these instructions easy to understand? how often did providers ask you to describe how you were going to follow these instructions? how often were you offered help in filling out a form at the provider's office?) have been included in the 2011 fielding of the national household survey MEPS (Medical Expenditure Panel Survey). These items will be fielded 3 times in the 2011-2020 period to provide data for Healthy People 2020 health communication goals.

While we do not know of any consumer reporting of measures from this item set, interest has been expressed by the MidWest Business Group on Health in fielding the item set to members of regional health plans.

3a.2.Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: The data from the 3 fieldings of items in MEPS will be published in the National Healthcare Disparities Report to serve as national benchmarks for those who are using these items. Stakeholders who are the targeted consumers of these 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, URAC) increasingly call for providers to address health literacy. The CAHPS Item Set for Addressing Health Literacy 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].

Highmark, a Medicaid health plan, added two items to their member survey: "Did your provider give you easy to understand instructions about taking care of your health problems or concerns?" and "How often did your provider ask you to describe how you were going to follow these instructions?" A disparity was identified among minority patients with respect to the first question. Interventions targeting minority members were developed with cultural competency and health literacy concepts in mind.

Items are used to evaluate quality improvement projects as part of a Part IV Maintenance of Certification offered by the American Board of Internal Medicine. Participants attend an in-person health literacy training, select a health literacy improvement project, and field items from the CAHPS Item Set for Addressing Health Literacy prior to and after implementing their quality improvement project to measure impact.

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

Items are specific enough to see whether health literacy improvement strategies (e.g., "teach-back") are being implemented. They also provide specific feedback on what behaviors may be leading to misunderstanding (e.g., talking too fast, using medical jargon) or better communication (e.g., easy-to-understand instructions).

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
Survey of patients

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)*: No 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)*:
To maximize response rates among Spanish speakers, respondents identified as Spanish-speaking in the sample file were mailed

materials in both English and Spanish. Respondents were mailed an advance notification letter letting them now about the survey. The survey was mailed with a cover letter from RAND approximately one week after the advance notification letter was mailed out. The cover letter provided basic information about the purpose of the survey, the confidentiality of the information provided, and how the data would be used. To evaluate the effect of sending a reminder letter, we conducted an experiment whereby half of the respondents were randomly selected to receive a reminder letter two weeks after the initial mailing of the survey. Two weeks after mailing the reminder letter, non-respondents were mailed a second copy of the survey with another reminder letter. Two weeks after mailing the second copy of the survey, non-respondents were routed to a phone center for phone follow up where multiple attempts at different times of the day were made to complete the survey by phone. Respondents who completed and returned the survey or completed the survey by telephone were mailed a thank you-letter.

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 <u>NQF-endorsed measure(s)</u>**:**
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, 20910

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:
Agency for Healthcare Research and Quality (AHRQ)
RAND Corporation
AIR
Harvard
The CAHPS Consortium (AHRQ, Yale, RAND, and Westat)

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.
Beverly Weidmer, RAND
Cindy Brach, AHRQ
Ron Hays RAND/UCLA

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: 2009
Ad.4 Month and Year of most recent revision: 01, 2012
Ad.5 What is your frequency for review/update of this measure? No regular schedule
Ad.6 When is the next scheduled review/update for this measure?

Ad.7 Copyright statement: The CAHPS Item Set for Addressing Health Literacy is in the public domain.

Ad.8 Disclaimers:

Ad.9 Additional Information/Comments:

Date of Submission (*MM/DD/YY*): 01/18/2012

CAHPS Item Set to Address Health Literacy 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**

The questions in this survey will refer to the provider named in Question 1 as "this provider." Please think of that person as you answer the survey.

HL1. 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

HL2. 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

HL3. 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

HL4. In the last 12 months, how often did this provider use pictures, drawings, models, or videos to explain things to you?

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

HL5. 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

HL6. In the last 12 months, how often did this provider interrupt you when you were talking?

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

HL7. 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

HL8. 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

HL9. In the last 12 months, how often did this provider give you all the information you wanted about your health?

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

HL10. In the last 12 months, how often did this provider encourage you to talk about all your health questions or concerns?

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

HL11. In the last 12 months, did you see this provider for a specific illness or for any health condition?

¹☐ Yes
²☐ No → **If No, go to #HL17**

HL12. In the last 12 months, did this provider give you instructions about what to do to take care of this illness or health condition?

¹☐ Yes
²☐ No → **If No, go to #HL16**

HL13. In the last 12 months, how often were these instructions easy to understand?

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

HL14. In the last 12 months, how often did this provider ask you to describe how you were going to follow these instructions?

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

HL15. Sometimes providers give instructions that are hard to follow. In the last 12 months, how often did this provider ask you whether you would have any problems doing what you need to do to take care of this illness or health condition?

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

HL16. In the last 12 months, how often did this provider explain what to do if this illness or health condition got worse or came back?

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

HL17. 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

HL18. In the last 12 months, did this provider prescribe any new medicines or change how much medicine you should take?

1☐ Yes
2☐ No → **If No, go to Core #21**

HL19. In the last 12 months, did this provider give instructions about how to take your medicines?

¹☐ Yes
²☐ No → **If No, go to #HL21**

HL20. In the last 12 months, how often were these instructions about how to take medicines easy to understand?

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

HL21. In the last 12 months, did this provider explain the possible side effects of your medicines?

¹☐ Yes
²☐ No → **If No, go to #HL23**

HL22. In the last 12 months, how often were these explanations was easy to understand?

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

HL23. In the last 12 months, other than a prescription, did this provider give you written information or write down information about how to take your medicines?

¹☐ Yes
²☐ No → **If No, go to #HL25**

HL24. In the last 12 months, how often was the written information you were given easy to understand?

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

HL25. In the last 12 months, how often did this provider suggest ways to help you remember to take your medicines?

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

Core 21. In the last 12 months, did this provider order a blood test, x-ray, or other test for you?

1☐ Yes
2☐ No → **If No, go to #HL27**

Core 22. In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?

1☐ Never→ **If Never, go to #HL27**
2☐ Sometimes
3☐ Usually
4☐ Always

HL26. In the last 12 months, how often were the results of your blood test, x-ray, or other test easy to understand?

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

Core 23. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

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

HL27. In the last 12 months, did you sign any forms at this provider's office?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #HL29**

HL28. In the last 12 months, how often did someone explain the purpose of a form before you signed it?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

HL29. In the last 12 months, did you fill out any forms at this provider's office?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to Core #24**

HL30. In the last 12 months, how often were you offered help to fill out a form at this provider's office?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

HL31. In the last 12 months, how often were the forms from this provider's office easy to fill out?

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

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: _____

_____

_____