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 #: 1919 **NQF Project:** Healthcare Disparities Project

(for Endorsement Maintenance Review)
Original Endorsement Date: **Most Recent Endorsement Date:**

BRIEF MEASURE INFORMATION

De.1 **Measure Title:** Cultural Competency Implementation Measure

Co.1.1 **Measure Steward:** RAND Corporation

De.2 **Brief Description of Measure:** The Cultural Competence Implementation Measure is an organizational survey designed to assist healthcare organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed® cultural competency practices prioritized for the survey. The target audience for this survey includes healthcare organizations across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations. Information from the survey can be used for quality improvement, provide information that can help health care organizations establish benchmarks and assess how they compare in relation to peer organizations, and for public reporting.

2a1.1 **Numerator Statement:** The target audience for this survey includes health care organizations across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations. The focus of the measure is the degree to which health care organizations have adopted or implemented 12 of the 45 NQF-endorsed cultural competency preferred practices.

2a1.4 **Denominator Statement:** As mentioned above, the survey can be used to measure adherence to 12 of the 45-NQF endorsed cultural competence preferred practices. The survey could be used to focus on a particular type of health care organization, or more broadly to collect information across various organization types.

2a1.8 **Denominator Exclusions:** Not applicable. The current version of the survey is designed to work across health care settings and different types of health care organization in terms of population served, size, and location.

1.1 **Measure Type:** Patient Engagement/Experience
2a1. 25-26 **Data Source:** Healthcare Provider Survey
2a1.33 **Level of Analysis:** Facility, Health Plan, Integrated Delivery System

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, OPPORTUITY, 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*): Care Coordination, 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)*:
Numerous studies have documented the existence of significant disparities in access to health care, outcomes, and health status among racial and ethnic minorities. Studies conducted across a variety of healthcare settings have found that racial/ethnic minority patients as well as those with low socioeconomic status or LEP report worse experiences of care, compared with whites, those with higher socioeconomic status, and English speakers. Growing evidence points to the fact that minority populations tend to receive lower quality of care even when factors such as access, health insurance, and income are taken into account. In short, racial and ethnic minorities face disproportionately higher rates of disease, disability, and mortality. For example, compared to whites, African Americans have higher death rates from heart disease, diabetes, AIDS, and cancer, and American Indians and Alaskan Natives have lower life expectancies and higher rates of infant mortality. Despite the fact that health care systems in the U.S. have improved over time, that racial and ethnic disparities have been widely documented, and that numerous attempts have been made to reduce or eliminate these disparities, they continue to be widespread and pervasive.

No doubt the causes of these health disparities are the result of multiple factors including bias (conscious or unconscious) on the part of the providers, differences in patients' expectations, miscommunication caused by cultural differences, and organizational factors that impact the quality of patient–provider interactions. However, there is also growing evidence that a major contributor to healthcare disparities is a lack of culturally competent care. Cultural competence can be defined as the ongoing capacity of healthcare systems, organizations, and professionals to provide diverse populations high quality care that is safe, patient and family centered, evidence-based, and equitable. To be culturally competent, health care providers have to employ various interpersonal and organizational strategies to overcome or at the very least reduce the barriers to access, communication, and understanding that stem from racial, ethnic, cultural, and linguistic differences. Providing culturally appropriate care has the potential to reduce disparities and improve outcomes while at the same time improving patient satisfaction.

In recent years, more and more organizations have begun exploring ways to improve cultural competency—that is, to ensure that diverse patient populations receive high-quality care that is safe, patient and family centered, evidence-based, and equitable. The National Quality Forum (NQF), an organization dedicated to improving healthcare quality, aims to promote culturally competent care, to reduce disparities, and to make care more patient-centered by endorsing a comprehensive framework for measuring and reporting cultural competency. It also endorsed a set of 45 preferred practices to provide culturally competent care. The framework and practices were published in an NQF report titled, "A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency", and cover issues such as communication, community engagement and workforce training, and providing healthcare systems with practices they can implement to help reduce persistent disparities in healthcare and create higher-quality, more patient-centered care.

1a.4 **Citations for Evidence of High Impact cited in 1a.3:** 1. Institute of Medicine (IOM), Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Washington, DC:
National Academies Press; 2002.

2. IOM, Crossing the Quality Chasm: A New Health System for
the 21st Century, Washington, DC: National Academy Press;

2001.

3. 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.

4. Collins KS, Hughes DL, Doty MM, Ives BL, Edwards JN, Tenney K. Diverse communities, common concerns: Assessing health care quality for minority Americans. New York: The Commonwealth Fund; 2002.

5. Wilson-Stronks A, Galvez E, Hospitals, Language, and Culture: A Snapshot of the Nation, Oakbrook Terrace, IL: The Joint Commission; 2008, pp. 60-64. Available at www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf. Last accessed February 2009.

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9. C. M. Ashton, P. Haidet, D. A. Paterniti et al., "Racial and Ethnic Disparities in the Use of Health Services: Bias, Preferences, or Poor Communication?" Journal of General Internal Medicine, 2003 18(2):146–152.

10. K. Fiscella, P. Franks, M. P. Doescher et al., "Disparities in Health Care by Race, Ethnicity, and Language Among the Insured: Findings from a National Sample," Medical Care, 2002 40(1):52–59.

11. P. Franks, K. Fiscella, and S. Meldrum, "Racial Disparities in the Content of Primary Care Office Visits," Journal of General Internal Medicine, 2005 20:599–603;

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13. Einbinder LC, Schulman KA, The effect of race on the referral process for invasive cardiac procedures, Med Care Res Rev, 2000;57(Suppl 1):162-180.

14. Mead H, Regenstein M, Lara A, The heart of the matter: the relationship between communities, cardiovascular services and racial and ethnic gaps in care, Manage Care Inferface, 2007;20(8):22-28.

15. Blackhall LJ, Murphy ST, Frank G, et al., Ethnicity and attitudes toward patient autonomy, JAMA, 1995;274(10):820-825.

16. Piette JD, Schillinger D, Potter MB, et al., Dimensions of patient-provider communication and diabetes self-care in an ethnically diverse population, J Gen Intern Med, 2003;18(8):624-633.

17. Jacobs EA, Lauderdale DS, Meltzer D, et al., Impact of interpreter services on delivery of healthcare to limited-English proficient patients, J Gen Intern Med, 2001;16(7):468-474.

18. Tocher TM, Larson EB, Do physicians spend more time with non-English-speaking patients? J Gen Intern Med, 1999;14(5):303-309.

19. Q. Ngo-Metzger, M. P. Massagli, B. Clarridge et al., "Health Care Experiences of Limited-English Proficient Chinese and Vietnamese Americans," Journal of General Internal Medicine,2003 18(S):184.

20. B. Smedley, A. Stith, A. Nelson, 2002; S. A. Fox and J. A. Stein, "The Effect of Physician–Patient Communication on Mammography Utilization by Different Ethnic Groups," Medical Care, 1991 29(11):1065–1082.

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26. M. D. Wong, S. M. Asch, R. M. Andersen et al., "Racial and Ethnic Differences in Patients' Preferences for Initial Care by Specialists," American Journal of Medicine, 2004 116(9):613–620.

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32. J. Whittle, J. Coniglaro, C. B. Good et al., "Racial Differences in the Use of Invasive Cardiovascular Procedures in the Department of Veterans Affairs Medical System," New England Journal of Medicine. 1993 329(9):621–627.

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34. Flores G, Language barriers to health care in the United States: perspective, N Engl J Med, 2006;355(3):229-231.

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36. Betancourt JR, Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic

Disparities in Health Care, New York: The Commonwealth Fund; 2006. Available at www.commonwealthfund.org/usr_doc/Betancourt_improvingqualityachievingequity_961.pdf?section=4039. Last accessed February 2009.
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37. 9. Paasche-Orlow M, The ethics of cultural competency, Acad Med, 2004;79(4):347-350.

38. Taylor SL, Lurie N, The role of culturally competent communication in reducing ethnic and racial healthcare disparities, Am J Manag Care, 2004;Spec No:SP1-4.

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 use the Cultural Competency Implementation Measure can use the results to evaluate their organization´s adherence to the 12 NQF-endorsed cultural competency practices covered in the survey, to identify areas for quality improvement within an organization (particularly related to making improvements in patients´ experience of care), to provide feedback to providers, and to inform consumers. Organization´s that field the survey measure can report scores for each of the 12 cultural competency preferred practices covered in the survey, as well as a total survey score. Health care organizations using this measure can use their practice (or subdomain) level score as well as their total survey score for benchmarking and reporting at the group or practice site level. For example, a health system may report their scores to compare adherence adherence to the NQF-endorsed cultural competency practices covered in the survey across provider groups or a provider group may compare performance across practice sites. In terms of quality improvement, the survey measure can generate data that organizations can use to improve specific areas related to specific NQF-endorsed cultural competency practices. Organizations can identify their strengths and weaknesses by preferred practice and once they have identified opportunities for improvement and embarked on quality improvement activities ,the organization can field the survey measure again to evaluate the success of improvement activities.

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.*]
As stated above, a review of racial and ethnic disparities in care indicate that minority populations tend to receive lower quality of care even when factors such as access, health insurance, and income are taken into account. One major contributor to healthcare disparities is a lack of culturally competent care (Brach and Fraser,2000). Numerous studies provide evidence of the gaps in healthcare providers´ and organizations´ performance when it comes to providing culturally competent care, that is, high quality care that at the same time is patient and family centered, sensitive to the needs and preferences of diverse populations, and equitable. There are numerous areas where there is evidence of gaps in performance. In the area of access to care, for example, previous research has shown that non-English speaking patients have worse access to care (Solis et al., 1990; Stein and Fox, 1990) and give poorer ratings of their care than English-speaking patients (Weech-Maldonado et al., 2001, 2003; Morales et al., 1999).

In the area of patient=provider communication, providers' non-verbal and interpersonal communication behaviors have been found to be particularly important for diverse patient populations. Hurtado et al, 2005 found that empathy and establishing rapport were more important to minority patients compared to White patients than the verbal transmission of health-related information. Similarly, African American, Hispanic, and Asian patients have been found to rate the provider's display of "concern, courtesy, and respect" as the most important factor in the interaction (Murray-Garcia et al., 2000; Napoles-Springer et al., 2005). Other studies have found that listening and spending adequate time are especially important for Asian (Ngo-Metzger et al., 2004) and Hispanic patients (Saha et al., 2003). Yet some studies have found that some racial/ethnic groups and those of lower socioeconomic status are more likely to report poor communication with their physicians (ARHQ, 2003). Findings from the Commonwealth Fund's 2001 Health Care Quality Survey (Collins et al., 2002) indicate that, while all demographic groups reported problems with patient-provider communication and interaction, difficulties were most pronounced for persons from racial/ethnic minority groups, low education,

low-health literacy, and low-income populations.

Building and/or promoting a patient's trust in their health care provider(s) and in the healthcare system is an important element of the health care encounter and another area where there is demonstrated evidence of performance gaps. Thom et al. (2002) 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 (Hunt et al., 2005). Several studies have found lower levels of patient trust among racial and ethnic minorities (Hunt et al., 2005; Schnittker, 2004; Meredith and Siu, 1995). Schnittker (2004) found that people of lower socio-economic status and members of racial and ethnic minorities were less trusting of their physicians and reported that their physicians were less responsive. Using data from a national sample of adults, Hunt et al. (2005) found that African Americans and Latinos were less trusting and less satisfied with their physicians than whites, and that the restrictiveness of an individual's health plan did not explain why some minority groups were less satisfied with their care. Finally, LaVeist et al. (2000) found that African Americans were significantly more likely than Whites to report mistrust of the medical system and racial discrimination in access to care. Those who perceived more racism and reported more mistrust of the medical care system were less satisfied with their care.

Yet another example of an area where there are demonstrated gaps in performance is in the provision of language assistance services to LEP patients. According to the U.S. census, more than 50 million people in the U.S. speak a language other than English at home and approximately 23 million are Limited English Proficient (LEP) (U.S. Census Bureau, 2008). Limited-English proficient (LEP) patients face language barriers when trying to access healthcare services across a range of settings, when receiving exams and lab tests, and when receiving medications. Many LEP patients have difficulty communicating their medical histories and understanding healthcare instructions. Their questions are often misunderstood, and medical decisions are sometimes made without their knowledge, understanding, and consent. According to The Joint Commission Poor communication leads to poor care and communication breakdowns are responsible for the nearly 3,000 unexpected deaths, catastrophic injuries, and other sentinel events reported each year (Joint Commission, 2007). LEP patients suffer a greater percentage of adverse events as a result of language breakdowns in 52% of reported cases, in comparison to English-speaking patients' 36% (Joint Commission, 2006). And yet many healthcare providers still rely on a patient´s family members to act as interpreters or use untrained bilingual staff, or language service providers that are poorly trained or monitored. A nationally representative survey in 2001 found that only 49% of Hispanic adults who said they needed medical interpretation always or usually got an interpreter (Doty, 2003). Of those who used an interpreter, 55% used ad-hoc interpreter, 43% relied on a family member or friend, and only 1% of the patients used a professional interpreter.

In short, there are many areas where there are demonstrated gaps in performance that could be overcome by providing more culturally competent care. By endorsing a comprehensive framework and preferred practices for measuring and reporting cultural competency, the National Quality Forum aims to provide a road map that health care providers and organizations can use for measuring and reporting cultural competency and in doing so promoting more culturally competent care, reducing disparities, and making care more patient centered.

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*]**

Brach, C. and Fraser, I. (2000). Can cultural competency reduce racial and ethnic racial health disparities? A review and conceptual model. Medicare Care Research Review, 57(Supplement 1): 181-217.

Solis JM, Marks G, Garcia M, Shelton D. Acculturation, access to care, and use of preventive services by Hispanics: findings from HHANES 1982-84. Am J Public Health. 1990;80(Suppl):11-19.

Stein JA, Fox SA. Language preference as an indicator of mammography use among Hispanic women. J Natl Cancer Inst. Nov 7 1990;82(21):1715-1716.

Weech-Maldonado R, Morales LS, Spritzer K, Elliott M, Hays RD. Racial and ethnic differences in parents´ assessments of pediatric care in Medicaid managed care. Health Serv Res. Jul 2001;36(3):575-594.

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Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD. Are Latinos less satisfied with communication by health care providers? J Gen Intern Med. Jul 1999;14(7):409-417.

Hurtado M, Frazier K, Levin A, Eisenhart E, Shore K. Valued Aspects of Ambulatory Care: Comparing Patients and Providers Based on Office Visit Accounts. Boston 2005.

Murray-Garcia JL, Selby JV, Schmittdiel J, Grumbach K, Quesenberry CP, Jr. Racial and ethnic differences in a patient survey: patients´ values, ratings, and reports regarding physician primary care performance in a large health maintenance organization. Med Care. Mar 2000;38(3):300-310.

Napoles-Springer AM, Santoyo J, Houston K, Perez-Stable EJ, Stewart AL. Patients´ perceptions of cultural factors affecting the quality of their medical encounters. Health Expect. Mar 2005;8(1):4-17.

Ngo-Metzger Q, Legedza AT, Phillips RS. Asian Americans´ reports of their health care experiences. Results of a national survey. J Gen Intern Med. Feb 2004;19(2):111-119.

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Agency for Health care Research and Quality (AHRQ). National Healthcare Disparities Report. Rockville: U.S. Department of Health and Human Services; 2003.

Collins KS, Hughes D, Doty MM, Ives BL, Edwards JN, Tenney K. Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans. New York: The Commonwealth Fund; March 2002.

Thom DH, Kravitz RL, Bell RA, Krupat E, Azari R. Patient trust in the physician: relationship to patient requests. Fam Pract. Oct 2002;19(5):476-483.

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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.

U.S. Census Bureau, 2008 American Community Survey 3-Year Estimates

U.S. Census Bureau, 2008

Joint Commission 2007 Sentinel Event Data "What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety"

Joint Commission, Language proficiency and adverse events in US hospitals: a pilot study, December 2006

Doty M. Hispanic Patients´ Double Burden: Lack of Health Care Insurance and Limited English. The Commonwealth Fund. 2003.

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

As mentioned above, numerous studies have looked at disparities in access to healthcare and health outcomes by population group. Perhaps the most compelling summary of the data on disparities by population group was presented in a 2003 report by the

IOM (Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare). This report presents a summary of the evidence and finds that disparities are consistent across a range of illnesses and healthcare services.

There is a large body of literature documenting racial differences in the treatment of cardiovascular disease (Ayanian et al., 1993; Franks et al., 1993; Giles et al., 1995; Whittle et al., 1993; Einbinder and Schulman, 2000; Mead Regenstein, and Lara, 2007). Other studies have found racial differences in the rates of lung cancer surgery and immunizations (King and Brunetta, 1999; Prislin et al., 1998). In addition, greater morbidity and mortality from HIV have been observed for African American patients than Whites (King et al., 2004).

As mentioned above, other studies have shown that shown that non-English speaking patients have worse access to care (Solis et al., 1990; Stein and Fox, 1990) and give poorer ratings of their care than English-speaking patients (Weech-Maldonado et al., 2001, 2003; Morales et al., 1999).

Finally, The Institute of Medicine report, "Unequal Treatment (2002)," demonstrated alarming results tied to language barriers. The report cites that minorities, when compared to Caucasian Americans, receive lower quality of medical care resulting in overall poorer health. The report also indicated that language barriers — which result in miscommunication, poor decision-making, and ethical compromises — are a root cause of the findings. These findings are supported by other studies. According to The Joint Commission poor communication leads to poor care and communication breakdowns are responsible for the nearly 3,000 unexpected deaths, catastrophic injuries, and other sentinel events reported each year (Joint Commission, 2007). LEP patients suffer a greater percentage of adverse events as a result of language breakdowns in 52% of reported cases, in comparison to English-speaking patients' 36% (Joint Commission, 2006). According to the Office of Minority Health, language barriers lead to fewer physician visits, missed appointments,prescription medicine mistakes, repeat emergency room visits, and the reduced use of preventive services among LEP patients (Office of Minority Health U.S. Department of Health and Human Services, March 2002).

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*]

Institute of Medicine (IOM), Unequal Treatment: Confronting
Racial and Ethnic Disparities in Health Care, Washington, DC:
National Academies Press; 2002.

Ayanian JZ, Udvarhely IS, Gatsonis CA, Pashos CL, Epstein AM. Racial differences in the revascularization procedures after angiography. Journal of the American Medical Association. May 1993 1993:2642-2646.

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Giles WH, Anda RF, Casper ML, Escobedo LG, Taylor HA. Race and sex differencees in rates of invasive cardiac proceudres in U.S. hospitals. Archives of Internal Medicine. 1995;155(3):318-324.

Whittle J, Coniglaro J, Good CB, Lofgren RP. Racial differences in the use of invasive cardiovascular procedures in the Department of Veterans Affairs medical system. New England Journal of Medicine. 1993;329(9):621-627.

Einbinder LC, Schulman KA, The effect of race on the referral process for invasive cardiac procedures, Med Care Res Rev, 2000;57(Suppl 1):162-180.

Mead H, Regenstein M, Lara A, The heart of the matter: the relationship between communities, cardiovascular services and racial and ethnic gaps in care, Manage Care Inferface, 2007;20(8):22-28.

King TE, Brunetta P. Racial disparity in rates of surgery for lung cancer. New England Journal of Medicine. 1999;341(16):1231-1233.

Prislin R, Dyer JA, Blakely CH, Johnson CD. Immunization status and sociodemographic characteristics: the mediating role of beliefs, attitudes, and perceived control. American Journal of Public Health. 1998;88(12):1821-1826.
King WD, Wong MD, Shapiro MF, Landon BE, Cunningham WE. Does racial concordance between HIV-positive patients and their

physicians affect the time to receipt of protease inhibitors? J Gen Intern Med. Nov 2004;19(11):1146-1153.

Solis JM, Marks G, Garcia M, Shelton D. Acculturation, access to care, and use of preventive services by Hispanics: findings from HHANES 1982-84. Am J Public Health. 1990;80(Suppl):11-19.

Stein JA, Fox SA. Language preference as an indicator of mammography use among Hispanic women. J Natl Cancer Inst. Nov 7 1990;82(21):1715-1716.

Weech-Maldonado R, Morales LS, Spritzer K, Elliott M, Hays RD. Racial and ethnic differences in parents´ assessments of pediatric care in Medicaid managed care. Health Serv Res. Jul 2001;36(3):575-594.

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 Serv Res. Jun 2003;38(3):789-808.

Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD. Are Latinos less satisfied with communication by health care providers? J Gen Intern Med. Jul 1999;14(7):409-417.

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.

Joint Commission 2007 Sentinel Event Data "What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety"

Joint Commission, Language proficiency and adverse events in US hospitals: a pilot study, December 2006

Office of Minority Health U.S. Department of Health and Human Services, March 2002

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

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

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	**M-H**	**M-H**	**Yes**☐
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 Cultural Competency Implementation Survey is designed to collect information on adherence to 12 of the 45 NQF-endorsed® cultural competency practices and to assist healthcare organizations in identifying the degree to which they are providing culturally competent care. The survey will serve as a resource for an organizational assessment of services provided for culturally diverse populations and adherence to NQF-endorsed® cultural competency practices. The results of the survey may be used by healthcare organizations to identify areas for quality improvement and by NQF and other organizations and stakeholders to recognize healthcare organizations that have adopted the preferred practices for providing culturally competent care.

The target audience for this survey includes healthcare organizations across a range of health care settings including hospitals, health plans, community clinics, dialysis organizations, etc. In addition, the target audience for this survey includes quality improvement organizations, accrediting organizations, organizations and agencies dedicated to improving the quality of health care

and patient safety, and the research community interested in reducing disparities in health care access and outcomes.

The survey measure is closely aligned with the cultural competency framework and preferred practices described in NQF's Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency. An expert panel convened by NQF identified 13 of the 45 preferred practices endorsed by NQF that should be prioritized by this survey measure (the 13 preferred practices cover the seven domains included in the framework). The final version of the measure covers 12 of the 13 preferred practices across the seven domains in the framework (one of the practices had to be dropped in order to reduce the length of the survey). The domains and subdomains covered by the survey include:

Domain 1: Leadership
Dedicated Staff and Resources (Preferred Practice 5)
Leadership Diversity (Preferred Practice 4)
Commitment to Serving A Diverse Population (Preferred Practice 3)

Domain 2: Integration into Management Systems and Operations
Strategic Planning (Preferred Practice 8)
Reward Systems (Preferred Practice 10)

Domain 3: Patient-Provider Communication
Language Access (Preferred Practice 12)

Domain 4: Care Delivery and Supporting Mechanisms
Clinical Encounter (Preferred Practice 23)

Domain 5: Workforce Diversity and Training
Training Commitment and Content (Preferred Practice 30)

Domain 6: Community Engagement
Community Outreach (Preferred Practice 32)

Domain 7: Data Collection, Public Accountability, and Quality Improvement
Quality Improvement (Preferred Practice 40)

Domain 7: Data Collection, Public Accountability, and Quality Improvement
Collection of Patient Cultural Competency-Related Information (Preferred Practice 37)

Domain 7: Data Collection, Public Accountability, and Quality Improvement
Assessment of Patient Experiences with Care (Preferred Practice 43)

The Cultural Competence Implementation Survey measure is designed as a single measure intended to be applicable across all settings of care. The survey uses the 4 A Adoption Framework (developed by C. Denham of TMIT in 2001) in formulating the survey questions. This framework is designed to assess an organization's adoption of a preferred practice by defining dimensions of progress using the following concepts:

? Awareness: Refers to whether an organization has awareness of performance gaps related to a particular preferred practice and/or is aware of issues necessary for the adoption or improvement of a preferred practice;

? Accountability: Refers to whether the organization creates an environment or collects information to inform and/or improve performance;

? Ability: Refers to whether the organization has the ability or the information, or creates the environment to adopt or implement new practices or improve existing ones;

? Action: Refers to whether the organization engages in sustained action that is measurable both by process measures as well as outcome measures that clearly tie to closing performance gaps.

Survey questions are grouped along the four "dimensions of progress" mentioned above and allow the survey results to describe the degree to which an organization has implemented or adopted any one of the preferred practices covered in the survey.

The domains and subdomains covered by the Cultural Competency Implementation Survey measure were identified by an expert panel as the key domains and subdomains that healthcare organizations need to focus on in order to meet the needs of diverse populations and provide more culturally competent care. Several studies have identified the provision of culturally competent care as essential for reducing racial and ethnic disparities in access to care as well as health outcomes. Healthcare organizations, however, first need to commit to serving diverse populations by recruiting and hiring diverse staff at all levels of the organizations (including leadership/management levels), providing cultural competence training, securing resources for providing culturally competent care, providing adequate language services, collect race/ethnicity data at the patient level in order to adequately monitor access to care and health outcomes by race/ethnicity, and collect patient experience of care data in order to monitor how well the organization is meeting their patients´ needs and preferences. The survey measure is designed to collect information to assess healthcare organizations´ progress in implementing these practices.

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

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)*:
Numerous studies link the domains and subdomains covered in the Cultural Competency Implementation Survey measure to access, trust in providers, language barriers, satisfaction, and other health outcomes.

For example, several studies have found that language concordant encounters result in better communication, interpersonal processes, and health outcomes than language discordant encounters:

Grantmakers in Health (GIH), In the Right Words: Addressing Language and Culture in Providing Health Care, Washington, D.C., 2003(Issue Brief #18).

M. M. Doty, Hispanic Patients' Double Burden: Lack of Health Care Insurance and Limited English, New York: The Commonwealth Fund. 2003.

New California Media (NCM), Bridging Language Barriers in Health Care: Public Opinion Survey of California Immigrants from Latin America, Asia and the Middle East. Los Angeles, CA: The California Endowment, 2003.

R. Seijo, H. Gomez, and J. Freidenberg, "Language as a Communication Barrier in Medical Care for Hispanic Patients," Hispanic Journal of Behavioral Sciences, 1991, 13(4):363–376.

E. Wilson, A. H. Chen, K. Grumbach et al., "Effects of Limited English Proficiency and Physician Language on Health Care Comprehension," Journal of General Internal Medicine,2005 20(9):800–806.

Other studies have found that patients have higher levels of trust in their provider in racially concordant encounters and 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.

Thom DH, Kravitz RL, Bell RA, et al. Patient trust in the physician: relationship to patient requests. Family Practice 2002;19:476-483

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

Schnittker J. Social distance in the clinical encounter: interactional and sociodemographic foundations for mistrust in physicians. Social Psychology Quarterly 2004;67:217-235

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

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

As mentioned above, several organizations and numerous studies have documented the impact of inadequate language services: mis-communication, errors in understanding, and poor decision-making. Language barriers lead to fewer physician visits, missed appointments, prescription medicine mistakes, repeat emergency room visits, and the reduced use of preventive services among LEP patients. The Joint Commission estimates that communication breakdowns are responsible for the nearly 3,000 unexpected deaths, catastrophic injuries, and other sentinel events reported each year (Joint Commission, 2007). LEP patients suffer a greater percentage of adverse events as a result of language breakdowns in 52% of reported cases, in comparison to English-speaking patients' 36% (Joint Commission, 2006).

Institute of Medicine (IOM), Unequal Treatment: Confronting
Racial and Ethnic Disparities in Health Care, Washington, DC:
National Academies Press; 2002.

Joint Commission 2007 Sentinel Event Data "What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety"

Joint Commission, Language proficiency and adverse events in US hospitals: a pilot study, December 2006

Office of Minority Health U.S. Department of Health and Human Services, March 2002

1c.5 **Quantity of Studies in the Body of Evidence** *(Total number of studies, not articles)***:** A total of 14 studies were referenced above as examples of studies that are linked to the domains and subdomains covered in the Cultural Competence Implementation Survey measure. However, this is but a small subset of studies in the body of evidence and are provided only as examples. The IOM report on racial and ethnic disparities (Institute of Medicine (IOM), Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Washington, DC:
National Academies Press; 2002), presented the results of a comprehensive literature review of over 600 articles published between 1992-2002.

1c.6 **Quality of Body of Evidence** (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*)**:** The extensive literature review conducted for the 2002 IOM report included only studies that had been published in peer-reviewed journals in the previous 10 years and whose primary purpose was to examine variation in medical care by race and ethnicity, contained original findings, and met generally established principles of scientific research. In addition, to ensure the comprehensiveness of the literature review, the reviewers searched for studies that attempted to assess variations in care by patient socioeconomic status and geographic region (to avoid only including studies with positive findings of racial and ethnic differences). To assess the quality of the evidence base, the literature review committee then ranked studies on several criteria: adequacy of control for insurance status; use of appropriate indicators for patient socioeconomic status; analysis of clinical data; prospective or retrospective data collection; appropriate control for patient co-morbid conditions; appropriate control for racial differences in disease severity or stage of illness at presentation; assessment of patients´ appropriateness for procedures; and finally, assessment of rates of refusal or patient preferences for non-invasive treatment.

1c.7 **Consistency of Results across Studies** *(Summarize the consistency of the magnitude and direction of the effect):* A review of the extensive literature on racial and ethnic disparities in access to care and in health outcomes points to the fact that the

evidence is consistent across a range of illnesses and health care services. The 2002 IOM report finds that while disparities are associated with socioeconomic factors and tend to diminish significantly when socioeconomic factors are controlled, the vast majority of studies reviewed show that racial and ethnic differences remain even after adjustment for socioeconomic differences and other healthcare access factors (Institute of Medicine (IOM), Unequal Treatment: Confronting
Racial and Ethnic Disparities in Health Care, Washington, DC:
National Academies Press; 2002).

There is growing evidence that cultural competence strategies and practices such as those covered in the Cultural Competency Implementation Survey measure serve to improve the delivery of care to diverse populations and impact health service utilization while increasing provider knowledge and improving patient satisfaction (Fortier and Bishop, 2004; AHRQ, 2004).

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.

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.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? No

1c.10 **If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:** Not applicable.

1c.11 **System Used for Grading the Body of Evidence:** Other

1c.12 **If other, identify and describe the grading scale with definitions:** Not applicable.

1c.13 **Grade Assigned to the Body of Evidence:** Not applicable.

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

1c.15 **Citations for Evidence other than Guidelines*(Guidelines addressed below)*:**
Not applicable.

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 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.randsurvey.org/ccis/

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

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

2a1.1 Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome)***:**
The target audience for this survey includes health care organizations across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations. The focus of the measure is the degree to which health care organizations have adopted or implemented 12 of the 45 NQF-endorsed cultural competency preferred practices.

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)***:**
The questions included in the survey ask the responding organization to report whether they have implemented or adopted various actions in support of one of the 12 cultural competence preferred practices covered in the survey by choosing one of 5 response options (no; yes, withing the last 12 months; yes, withing the last 13-24 months; yes, withing the last 25=36 months; and yes, more than 36 months ago). For certain questions where the NQF preferred practice statement specifically indicates that an activity or practice has to be implemented in the last 12 months, the survey question uses a 12-month reference period.

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***:**
The survey can be used across health care settings with different types of health care organizations. The survey includes a section designed to collect information that describes the organization completing the survey (organization name, telephone number, organization type, organization part of a larger health care system and if yes, the name of the system, name of CEO, name of person completing the survey, title, telephone number, email address).

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)***:**
As mentioned above, the survey can be used to measure adherence to 12 of the 45-NQF endorsed cultural competence preferred practices. The survey could be used to focus on a particular type of health care organization, or more broadly to collect information across various organization types.

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

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion)*:
The survey asks participating organization to report on activities they have engaged in, in order to adopt of implement the 12 NQF-endorsed practices covered by the survey, using one of 5 response options (no; yes, withing the last 12 months; yes, withing the last 13-24 months; yes, withing the last 25=36 months; and yes, more than 36 months ago). For certain questions where the NQF preferred practice statement specifically indicates that an activity or practice has to be implemented in the last 12 months, the survey question uses a 12-month reference period.

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)*:
In order to identify and calculate the target population, survey users must clearly identify the type of health care organizations they aim to include in the survey, and the number of organizations by type they are including in the survey.

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
Not applicable. The current version of the survey is designed to work across health care settings and different types of health care organization in terms of population served, size, and location.

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)*:
N/A

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)*:
N/A

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

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

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

2a1.17-18. Type of Score:

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.)*:
The Cultural Competency Implementation Measure is specifically designed to collect information on an organization's progress on 12 of the NQF-endorsed® cultural competency practices. Each practice is assigned an individual weight, which is factored into the overall score. The aim is to rank organizations by quartiles based on their relative progress out of the total number of possible points. The scales associated with each of the preferred cultural competency practices that are covered by the survey are weighted

differently for purposes of scoring but equal weighting is used for the survey items that comprise the scale. The maximum number of points for each scale based on the relative impact of the cultural competency practice with which it is associated. Table 3 below provides an overview of the scoring for each of the practices covered by the survey. The maximum number of points for all practices combined is 142.

Table 3
Scoring by Preferred Practice
Practice Name and Number Weighting (pts)

Preferred Practice 12:	19 points
Preferred Practice 5:	17 points
Preferred Practice 4:	14 points
Preferred Practice 3:	13 points
Preferred Practice 30:	11 points
Preferred Practice 32:	11 points
Preferred Practice 40:	12 points
Preferred Practice 23:	10 points
Preferred Practice 37:	11 points
Preferred Practice 43:	11 points
Preferred Practice 8:	8 points
Preferred Practice 10:	5 points
TOTAL POINTS	142

As mentioned above, within the scale for each practice, each question has an equal point value, computed as the maximum points for that scale divided by the number of questions that an organization provided a response for in that scale. Item response categories for each question are scored as follows:

- No=0
- Yes, within the last 12 months=100
- Yes, within the last 12 months=75
- Yes, within the last 12 months=50
- Yes, within the last 12 months=25

Survey items for which a respondent can select more than one response option are scored as follows:

- No=0
- If 1 yes checked=1
- If 2 yes checked=2
- If 3 yes checked=3

Scores are then transformed linearly to 0-100 possible range, resulting in scores of approximately 0, 33.33, 66.66, and 100.

The overall score for a survey is the sum of all the points earned for each of the scales included in the survey. The sum of the points earned across all scales in the survey is multiplied by the ratio of 142 maximum points to the sum of available points for each practice. All survey scores will be normalized to 100. All organizations that complete a survey are stratified into quartiles based on their overall points. In order to receive the highest level of recognition, an organization must be in the top quartile of responding organizations in terms of their overall points.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:
Attachment
NQF_Survey_FinalReport_23DEC11_tp.pdf

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

The survey is designed to be fielded as a web-based survey. To increase participation, survey users are encouraged to allow a 6-8 week data collection period, to time the survey to avoid competing with other surveys and/or to avoid national holidays, and to seek the endorsement of organizations that could be crucial in encouraging participation in the survey. In addition, to maximize response rates, survey users need to follow-up by email and telephone with non responders to the web survey. To reduce the burden on survey respondents, it is also useful to FedEx or mail each respondent a packet that includes a survey cover letter and instructions for accessing the survey, a copy of the survey, guidance document, and the NQF consensus report. A pdf copy of each of these documents should also be made available from the web-survey's home page, in the event respondents needed to print another copy. The survey cover letter that survey users should use to invite organizations to take part in the survey should include the url for the web survey and provide each respondent with a unique pin number that they are required to enter in order to access the survey.

Prior to completing the survey, respondents should review the NQF report, the guidance document, and the survey prior and use the hard copy of the survey to complete the survey off-line first, and then once completed, to log in to the web survey to enter their responses on-line. In the event they prefer to send in their completed hard copy surveys, respondents should also be provided a mailing address and fax number to which they could send their completed survey if they prefer. In addition, respondents should be provided an email address and a telephone number to call in the event they have questions or comments about the survey or experience technical difficulties in accessing the web survey.

After the initial mailing of the survey, respondents who have not completed the survey should be mailed a reminder email (or letter in the event we did not have a valid email for them). One week after the mailing of the reminder, initiate phone follow-up to all organizations that had not yet completed the survey. Multiple attempts should be made to reach the designated respondent at each organization both by phone and via email. To encourage participation and increase the response rate, a 6-8 week field period. Following completion of the survey, participating organizations should receive a thank you letter with a gift card to thank them for completing the survey (if applicable), as well as information on their total survey score, their score by practice, and information on how they scored in relation to peer organizations that participated in the survey.

The expected response rate for the survey is expected to range between 30-50% depending on the quality of the sample data, how motivated organizations are to complete the survey, and the type of support the survey has from stakeholder organizations. The sample size for the survey will vary depending on the type of organization that will be included in the survey, but assuming a 30% response rate, survey users need to include a sample of ~350 organizations by type of organization in order to obtain ~100 completes by type of organization. Although additional analysis needs to be completed, we estimate that you need ~100 completed surveys in order to be able to obtain organization-level estimates and average scores.

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

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment: URL
https://www.randsurvey.org/ccis/

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:
URL
https://www.randsurvey.org/ccis/

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested)***:** Facility, Health Plan, Integrated Delivery System

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, Dialysis Facility, Hospice, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation

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)***:**
Field-testing the Cultural Competency Implementation Survey Measure with a broad range of health care organizations was crucial to evaluating whether the survey can indeed be used across a range of health care settings. Thus, in constructing the sample for the field test, we aimed to include as many different types of organizations as possible and to include organizations that we thought would be particularly interested in cultural competence issues related to serving diverse populations. To evaluate whether the survey works equally well across organizations regardless of organization size, we aimed to include small, medium, and large facilities and organizations. Given the length of the survey, we were especially concerned about the response rate we would be able to achieve and about our ability to obtain enough completed surveys to allow us to adequately examine the reliability and validity of the survey. Although we had originally proposed to conduct the field test with a sample of 125 organizations, we increased the sample to 269 in order to include a more diverse mix of organizations. We reached out to various stakeholders and organizations for assistance in identifying a sample for the field test, to obtain support for the field test, and to motivate participation. These organizations included the End Stage Renal Disease Network in Texas, America's Health Insurance Plans, the National Health Plan Collaborative, the National Association of Community Health Centers, and the Office of Quality and Data, Health Resources and Services Administration of the U.S. Department of Health and Human Services.

The sample for the field test included 115 hospitals throughout the U.S. that had participated in a cultural competence survey previously, 126 federally qualified health centers (including community clinics and medical groups) located in California only, 19 health plans that are participating in the National Health Plan Collaborative and are interested in issues related to cultural competence and improving care for diverse populations, 2 integrated health systems (that had participated in the cognitive interviews used to evaluate the survey and had expressed an interest in participating in the field test), and 7 dialysis facilities in Texas. The Cultural Competency Implementation Survey Measure was field tested in October and November of 2011 as a web survey with telephone, email, and mail follow-up. Fifty organizations completed the survey measure for a response rate of 18% (hospitals accounted for 8% of the completes, dialysis centers for 10%, FQHC´s for 55%, health plans for 18%, integrated health systems for 4%, and medical groups for 6%).

2a2.2 Analytic Method *(Describe method of reliability testing & rationale)***:**
The primary goal of the data analysis task was to evaluate the reliability and validity of the Cultural Competency Implementation Survey. Although we had also hoped to be able to examine whether response rates and reliability and validity varied by type of organization, we were unable to obtain enough observations for each type of organization included in the field test to reliably examine these issues.

Analyses of the field test data included examination of response rates, construct validity of responses including item distribution (ceiling and floor effects), item missing data, and internal consistency reliability of multi-item scales. To examine the reliability and validity of the survey, we estimated Cronbach's (1951) alpha and reliability for the scales for each of the selected core practices using ANOVA (two-way fixed effect and one-way models, respectively). In addition, we performed confirmatory factor analysis to assess the fit of the data to the hypothesized domain structure.

2a2.3 Testing Results *(Reliability statistics, assessment of adequacy in the context of norms for the test conducted)***:**
Overall, the results of the analysis of the field test of the survey measure demonstrate that it has adequate measurement properties and that it can be used to report results at the organizational level. The table below provides item-scale correlations for each of the 12 scales included in the survey. Correlations between items and scales revealed that the data were consistent with the hypothesized item clusters (scales). With a few exceptions, the variation in the distribution of responses is adequate. Question 1 showed in the scale for Preferred Practice 12 showed no variation in the distribution of responses (44 organizations answered "yes", and 3 answered "don't know", with no organizations reporting "no"). Post field test, we revised the wording to clarify the intent of the item. Three items showed adequate variation in the distribution of responses but had poor item-scale correlations (item 11 in the scale for Preferred Practice 12 had an item-scale correlation = 0.15; item 3 in the scale for Preferred Practice 23 had an item scale correlation=0.22, and item 1 in the scale for Preferred Practice 40 had an item-scale correlation=0.25). However, we opted not to drop these items, because they are tied directly to specifications for the preferred practice they fall under. The psychometric results for item 11/PP 12 and item 1/PP40 need to be replicated with a larger sample to confirm the correlations.

Item-Scale Correlations

Domain/Subdomain: Domain 1: Leadership/
Commitment to Serving A Diverse Population
Scale: PP 3
# of Items: 6
Cronbach's Alpha: a=0.88
Item-Scale Correlations: 0.65-0.74

Domain/Subdomain: Domain 1: Leadership/
Commitment to Serving A Diverse Population
Scale: PP 4
# of Items: 8
Cronbach's Alpha: a=0.76
Item-Scale Correlations: 0.32-0.60

Domain/Subdomain: Domain 1: Leadership/
Commitment to Serving A Diverse Population
Scale: PP 5
# of Items: 8
Cronbach's Alpha: a=0.82
Item-Scale Correlations: 0.34-0.69

Domain/Subdomain: Domain 2: Integration into Management Systems and Operations/
Strategic Planning
Scale: PP 8
# of Items: 6
Cronbach's Alpha: a=0.85
Item-Scale Correlations: 0.49-0.78

Domain/Subdomain: Domain 2: Integration into Management Systems and Operations/
Strategic Planning
Scale: PP 10
# of Items: 8
Cronbach's Alpha: a=0.88
Item-Scale Correlations: 0.44-0.85

Domain/Subdomain: Domain 3: Patient-Provider Communication/
Language Access
Scale: PP 12
# of Items: 14
Cronbach's Alpha: a=0.81
Item-Scale Correlations: 0.15-0.69

Domain/Subdomain: Domain 4: Care Delivery and Supporting Mechanisms/ Clinical Encounter
Scale: PP 23
# of Items: 4
Cronbach's Alpha: a=0.82
Item-Scale Correlations: 0.22-0.86

Domain/Subdomain: Domain 5: Workforce Diversity and Training/ Training Commitment and Content
Scale: PP 30
# of Items: 10
Cronbach's Alpha: a=0.84
Item-Scale Correlations: 0.34-0.64

Domain/Subdomain: Domain 6: Community Engagement/ Community Outreach
Scale: PP 32
# of Items: 5
Cronbach's Alpha: a=0.81
Item-Scale Correlations: 0.32-0.80

Domain/Subdomain: Domain 7: Data Collection, Public Accountability, and Quality Improvement/ Collection of Patient Cultural Competency-Related Information
Scale: PP 37
# of Items: 7
Cronbach's Alpha: a=0.85
Item-Scale Correlations: 0.33-0.79

Domain/Subdomain: Domain 7: Data Collection, Public Accountability, and Quality Improvement/ Collection of Patient Cultural Competency-Related Information
Scale: PP 40
# of Items: 5
Cronbach's Alpha: a=0.75
Item-Scale Correlations: 0.25-0.63

Domain/Subdomain: Domain 7: Data Collection, Public Accountability, and Quality Improvement/ Collection of Patient Cultural Competency-Related Information
Scale: PP 43
# of Items: 10
Cronbach's Alpha: a=0.81
Item-Scale Correlations: 0.31-0.65

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:**
In developing the Cultural Competency Implementation Survey measure, we conducted two rounds of cognitive interviews to assess whether the survey items included in the survey measure were understood as intended across a range of respondents and healthcare organizations. That is, we specifically aimed to assess whether the scales included in the survey measure and whether specific items in each of the 12 scales included in the survey measure, were adequately capturing healthcare organizations´ experiences in implementing or adopting the NQF-endorsed cultural competency practices that were covered by the survey measure. Each of the 12 scales included in the survey were designed to measure adherence to a particular preferred practice and therefore, the main focus of the cognitive interviews was to assess whether the survey measures were adequately measuring adherence to the preferred practice. Post field test, we also reviewed and evaluated the comments included by respondents throughout the survey in an effort to evaluate whether the survey items/scales were being understood as intended and whether they were successfully measuring adherence to the preferred practice each of the scales was intended to cover.

Cognitive interviews have been found useful in detecting and minimizing some sources of measurement error by identifying concepts or terms that are difficult to comprehend, measures that are misinterpreted by respondents, and response options that are inappropriate for the question or that fail to capture a respondent's experience adequately.

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 interviews to evaluate the content validity of the survey measure were conducted with nine healthcare organizations (including health plans, two hospitals, an integrated health system, community clinics, and federally qualified health centers) as part of the measure development process. The sample for the field test included 269 healthcare organizations and included 115 hospitals throughout the U.S. that had participated in a cultural competence survey previously, 126 federally qualified health centers (including community clinics and medical groups) located in California only, 19 health plans that are participating in the National Health Plan Collaborative and are interested in issues related to cultural competence and improving care for diverse populations, 2 integrated health systems (that had participated in the cognitive interviews used to evaluate the survey and had expressed an interest in participating in the field test), and 7 dialysis facilities in Texas. Fifty organizations completed the survey measure for a response rate of 18% (hospitals accounted for 8% of the completes, dialysis centers for 10%, FQHC´s for 55%, health plans for 18%, integrated health systems for 4%, and medical groups for 6%).

2b2.2 **Analytic Method** *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)***:**
In developing the Cultural Competency Implementation Survey Measure, we conducted two rounds of cognitive interviews in September and October 2011. Cognitive interviews have been found useful in detecting and minimizing some sources of measurement error by identifying concepts or terms that are difficult to comprehend, measures that are misinterpreted by respondents, and response options that are inappropriate for the question or that fail to capture a respondent's experience adequately. In developing the Cultural Competency Implementation Survey, cognitive testing enabled us to assess whether potential respondents (organizations) understood the survey measures as intended and in the same way across health care settings, to assess the guidance document that accompanies the survey, to obtain feedback on issues and challenges related to fielding the survey, and to evaluate the burden placed on responding organizations that complete a survey as well as estimates of time to complete the survey. In addition, the cognitive interviews allowed us to identify other issues related to fielding the survey, including identifying the most appropriate person to complete the survey, whether the survey measure has to be completed by one or multiple respondents, the materials that should be mailed to respondents, and the best way for identifying and engaging respondents so that they will complete the survey in a timely fashion. We conducted two rounds of cognitive interviews with representatives from health care organizations from both in-patient as well as ambulatory facilities (5 interviews in the first round and 4 interviews in the second round).

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)***:**
The results of the first round of cognitive interviews indicated that for the most part, the scales and the survey items were easy to understand and were measuring adherence to the preferred practice they were intended to cover. However, some wording changes were required for some survey items in order to make the survey items more specific and easier to understand in a consistent manner across organizations. In addition, the 12 month reference period used in the survey proved problematic for several organizations and prevented them from reporting adoption or implementation of certain preferred practices when they ocurred outside the 12 month reference period. The respondents that participated in the cognitive interviews reported that organizational policies regarding certain practices (for example, reviewing the organization´s mission statement, etc.) are not done every 12 months but rather every 23 or 36 months, and felt that their adherence to this particular practice would be unfairly portrayed as a result of the 12 month reference period. We therefore dropped the 12 month reference period and opened up the response options to allow respondents to report on adherence to practices in the last 12 months, in the last 13-24 months, in the last 25-36 months, more than 36 months ago, or never. The cognitive interviews were also useful in modifying other response options to allow organization´s to report on partial implementation of a particular preferred practice (for example, providing staff with cultural competence training), shortening the survey by eliminating or combining questions that were perceived as redundant, and stream-lining the data collection process to reduce the burden on respondents.

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)***:**
Not applicable. Did not conduct analysis of exclusions.

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

Not applicable. Did not conduct analysis of exclusions.

2b3.3 **Results** *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*
Not applicable. Did not conduct analysis of exclusions.

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

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. Did not utilize a risk adjustment strategy.

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. Did not utilize a risk adjustment strategy.

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. Did not utilize a risk adjustment strategy.

2b4.4 **If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment:** Not applicable.

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

2b5.1 **Data/Sample** *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
The field test sample did not provide enough data to adequately examine meaningful differences in performance across participating organizations or within type of organizations. Going forward, we hope to be able to field the survey with a large enough sample to be able to look into this.

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)*: Not applicable.

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), Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

3.1 **Current Use** *(Check all that apply; for any that are checked, provide the specific program information in the following questions)*: Quality Improvement with Benchmarking (external benchmarking to multiple organizations), Quality Improvement (Internal to the specific organization)

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

3a.1. **Use in Public Reporting - disclosure of performance results to the public at large** *(If used in a public reporting program, provide name of program(s), locations, Web page URL(s)).* If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: **[*For Maintenance* –** *If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.***]**
The survey measure is not currently in use for public reporting but we strongly believe that it has the potential to be used for this purpose going forward. However, the survey measure needs to be evaluated with a larger sample than was possible as part of the survey measure development process in order to fully develop the scoring approach that would be required for public reporting (including examining any statistical variation between the average scores calculated for each of the scales, evaluating approaches for reporting different levels of achievement; setting a minimum passing score for each practice or domain as well as different levels of scoring for each domain, and establishing benchmarks and performance cut-off points.

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**:** As part of the survey development process, the survey measure was cognitively tested with various organizations using a scripted guide. The survey measure was revised and then subsequently field tested as a web survey with telephone and email follow-up. Information obtained through both the cognitive interviews and the field test provide evidence that the survey content resonated with a broad range of organizations (across healthcare settings) and found the survey easy to complete and understand (although in some cases, particularly for larger organizations, multiple departments withing the organization had to be involved). We used the field test data to calculate a score for each of the preferred practices covered in the survey, for each domain, and a total survey score. The total survey scores calculated as part of the field test range from 98 to 17 with a mean score of 65 and a median score of 69

percent. Following the field test we conducted 6 interviews with survey respondents to collect feedback on their experiences completing the survey.

3.2 **Use for other Accountability Functions (payment, certification, accreditation).** If used in a public accountability program, provide name of program(s), locations, Web page URL(s)**:** The survey measure is not currently in use for other Accountability functions. However, programs to accredit patient-centered medical homes (e.g., Joint Commission, NCQA) increasingly call for providers to be culturally competent. The Cultural Competence Implementation Measure could be used as a means of assessing whether standards for providing culturally competent care are being met and specifically, the degree to which healthcare organizations are adhering to the NQF-endorsed preferred practices for providing culturally competent care.

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*].
As the survey has only recently been made available to other organizations, to our knowledge, it is not yet currently in use.

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:
Again, the feedback we received in the two rounds of cognitive interviews conducted as part of the measure development process as well as feedback obtained via the field test and in the post field test interviews conducted provide strong evidence that there is a great deal of interest among a broad range of healthcare organizations in using information gathered through the survey to identify areas for quality improvement and to set benchmarks both internally and externally. Several of the organization representatives that took part in the interviews and field test specifically reported that the survey was useful in reminding them of cultural competence practices they need to focus on and provide actionable information specifically tied to the NQF-endorsed cultural competence practices covered by the survey measure.

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
Data elements are generated by fielding the Cultural Competence implementation Measure

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)***:** ALL data elements are in a combination of 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:**

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

4c.1 **Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:**
The survey measure is programmed for web survey administration which drastically reduces survey administration error (respondents are unable to leave fields blank or to enter responses other than those available in the survey). However, it is possible that the available survey responses don´t accurately capture the responding organization´s intended response. The

survey allows respondents to enter comments at the end of each section of the survey and then once more at the very end of the survey. Going forward, we will be evaluating the comments provided by respondents as well as any other feedback provided by respondents in order to assess whether there are any issues or problems either with the survey measures as currently worded, or the response scales provided in the survey measure. If necessary, we will revise the survey in the next version to be released. The algorithm for scoring the survey is also programmed as part of the survey so

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)***:**

The Cultural Competency Implementation Measure is designed to be administered as a web survey with the option of printing out the survey and completing it hardcopy. Upon completing the survey, respondents receive their total survey score as well as their score by practice (subdomain). Programming the survey for web administration has the advantage of making the survey easily accessible to respondents from any location, dramatically reduces the cost of implementing the survey, reduces measurement errors significantly given that respondents are forced to answer questions in a specific order, are not allowed to skip or leave survey items blank, and are not allowed to enter response options that are invalid or out of range. In addition, administering the survey over the web eliminates the need for data entry of survey responses and reduces the time required to process the survey data once the survey is completed. To increase response rates, we strongly encourage conducting phone follow-up using via telephone, email, fax, and even regular mail. Feedback received from survey organizations that participated in the field test conducted as part of the development of the measure would seem to indicate that the survey measure is easy to complete with survey completion times ranging from 15 minutes to 180 minutes (average time to complete the survey was 53 minutes). Although the survey measure was shortened and stream-lined as much as possible based on findings from the development and testing process, the survey measure is still rather lengthy. To reduce or limit the burden to participating organizations, the survey should probably not be fielded more than once per year. Our experience in field testing the survey measure also points to other things that one can do to motivate participation in the survey and reduce the burden on respondents. This includes carefully timing the survey to avoid competing with other organizational surveys, seeking the endorsement and support of the survey from stakeholder groups and member organizations, sending organizations selected to participate in the survey a hardcopy of the survey, guidance documentation, and other supporting documentation so that they don´t have to print it out themselves, and allowing participating organizations sufficient time to complete the survey (this is particularly important for large organizations that required the involvement of multiple departments and/or individuals in order to complete the survey). Finally, feedback received from organizations that participated in the field test indicates that a wide range of organizations have a great deal of interest in the survey, not only as a source of information they can use for quality improvement purposes, but also as a source of information for benchmarking performance and comparing themselves to peer organizations.

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:**

5a. **Harmonization**
5a.1 **If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized?** 5a.2 **If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:**
5b. **Competing Measure(s)**
5b.1 **If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures** *(e.g., a more valid or efficient way to measure quality)***; OR provide a rationale for the additive value of endorsing an additional measure.** *(Provide analyses when possible)***:**

CONTACT INFORMATION
Co.1 **Measure Steward (Intellectual Property Owner):** RAND Corporation, 1776 Main St., PO Box 2138, Santa Monica, California, 90401-2138 Co.2 **Point of Contact:** Beverly, Weidmer, MA, Beverly_Weidmer@rand.org, 310-393-0411-6788
Co.3 **Measure Developer if different from Measure Steward:** RAND Corporation, 1776 Main St., PO Box 2138, Santa Monica, California, 90401-2138 Co.4 **Point of Contact:** Beverly, Weidmer, MA, Beverly_Weidmer@rand.org, 310-393-0411-6788
Co.5 **Submitter:** Beverly, Weidmer, MA, Beverly_Weidmer@rand.org, 310-393-0411-6788, RAND Corporation
Co.6 **Additional organizations that sponsored/participated in measure development:**
Co.7 **Public Contact:** Beverly, Weidmer, MA, Beverly_Weidmer@rand.org, 310-393-0411-6788, RAND Corporation

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.** Paul M. Schyve, MD (Co-Chair) The Joint Commission Oakbrook Terrace, IL Kimberlydawn Wisdom, MD, MS (Co-Chair) Henry Ford Health System Detroit, MI Dale M. Allison, PhD Hawaii Pacific University College of Nursing and Health Sciences Kaneohe, HI Ignatius Bau, JD California Pan-Ethnic Health Network San Francisco, CA

Cindy Brach, MPP
Agency for Healthcare Research and Quality
Rockville, MD

J. Emilio Carrillo, MD, MPH
New York-Presbyterian Community Health Plan
New York, NY

Lisa A. Cooper, MD, MPH
Johns Hopkins University School of Medicine
Baltimore, MD

Ricardo Forbes, MPA
Baptist Health
Coral Gables, FL

Marcos Pesquera, RPh, MPH
Adventist Health System
Rockville, MD

Wayne S. Rawlins, MBA, MD
Aetna
Hartford, CT

Marsha Regenstein, PhD
George Washington University School of Public Health and Health Systems
Washington, DC

Kyu Rhee, MD, MPP
Health Resources and Services Administration
Rockville, MD

Kalahn A. Taylor-Clark, PhD, MPH
Brookings Institute
Washington, DC

Robert Weech-Maldonado, PhD
University of Alabama Birmingham
Birmingham, AL

Ann O. Wehr, MD
Molina Healthcare of New Mexico
Albuquerque, NM

Winston F. Wong, MD, MS
Kaiser Permanente
Oakland, CA

John M. Young, MA
Centers for Medicare & Medicaid Services
Baltimore, MD

This 17-person Expert Panel convened in 2010 and 2011 (prior to the start of the project to develop the survey measure) to provide

expertise and strategic direction for measurement of the NQF-endorsed® preferred practices for cultural competency. The Panel provided input and recommendations for the conceptual development of an implementation survey measure related to the cultural competency practices, strategies for implementing the practices in a range of care settings and from a multi-stakeholder perspective, and recommendations for measure concepts related to the cultural competency practices included in the implementation measure. As part of the survey development process, the survey developer presented the development approach and draft survey measures to the Expert Panel and sought feedback on issues related to content of the survey measure, measure recall period, and scoring approach.

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:** N/A

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:** 12, 2011
Ad.5 **What is your frequency for review/update of this measure?** Annually.
Ad.6 **When is the next scheduled review/update for this measure?** 02, 2012

Ad.8 **Disclaimers:** N/A

Ad.9 **Additional Information/Comments:** N/A

Date of Submission (*MM/DD/YY*)**:** 02/20/2012

Cultural Competency Implementation Survey

Version 1.6
December 20, 2011

ACKNOWLEDGMENTS
This survey is being developed prepared under contract to the
National Quality Forum by:
RAND Corporation
1776 Main Street
Santa Monica, CA 90401

Dear Participant,

Thank you for agreeing to complete the ***Cultural Competency Implementation Survey***. The purpose of the survey is to assist healthcare organizations in identifying the degree to which they are providing culturally competent care. The survey will serve as a resource for an organizational assessment of services provided for culturally diverse populations and adherence to NQF-endorsed® cultural competency practices. We hope the results of the survey will be used by healthcare organizations to identify areas for quality improvement.

Survey Overview

The design of the ***Cultural Competency Implementation Survey*** is closely aligned with NQF's Cultural Competency Framework and the NQF Cultural Competency preferred practices described in NQF's *Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency*. This document is the foundation for the development of the survey measure along with the recommendations made by an Expert Panel that reviewed the NQF report and identified the recommended conceptual structure of the survey measures, the practices that should be included (12 of the 45 cultural competency practices covering the 7 domains of the framework), and the weighting practices and specifications to be used when determining the scoring of the survey measure.

The survey is divided into 2 sections:

- The first section asks the respondent to provide general information about his/her organization.
- The second section includes the 12 preferred practices that are being assessed and are meant to provide information on an organization's adoption of the subset of cultural competency practices endorsed by NQF that are included in the survey.

Each question in the survey is designed to collect information on activities the organization has engaged in or information the organization has collected in order to implement, adopt or improve the preferred practice related to that survey question. Participating organizations are asked to provide a response for each question included in the survey, even if they are not working to adopt or implement one of the practices, if they don't know the answer to a question, or if they feel a particular practice does not apply to their organization.

Note: The web version of the survey includes a response option for "don't know" and "not applicable" for each question in the survey. In addition, if you have comments or observations you would like to make about the survey, the web based version of the survey will allow you to enter comments at the end of each survey section and once more at the end of the survey.

Each question in the survey includes a series of response options to describe whether an organization has engaged or adopted a particular practice and if so, when. If your organization performs a particular practice periodically or on an ongoing basis, please select the most recent time period when the activity took place (e.g. "yes, within the last 12 months"). In addition, please enter a comment in the "comments" box at the end of each section of the survey to indicate that your organization engages in a particular activity on an ongoing or periodic basis.

Please note that once the responses to all survey questions are entered using the web-based survey, survey respondents will be asked to submit their survey. Once the survey has been submitted, you will no longer have access to the survey.

Before completing the survey, please review the Guidance Document and Reference Manual that was mailed to you with the invitation letter. You may also want to refer to the NQF report titled *Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency* that was also mailed to you with the invitation letter. Both of these documents are available at https://www.randsurvey.org/ccis/.

Questions or comments
Please don't hesitate to contact Beverly Weidmer at (310) 393-0411, ext. 6788 or via email at Beverly_Weidmer@rand.org should you have any questions or comments about the survey or need additional information.

Glossary of Survey Terms

Below we provide the definition for a variety of terms used throughout the survey:

Health professional—Physicians, administrators, nurses, physical and occupational therapists, linguistic services providers, psychologist social workers, and others who provide care to a patient.

High-quality healthcare—Healthcare that is delivered in a safe, effective, patient-centered, timely, efficient, and equitable manner and that is state of the art and evidence based.

Leadership—In reference to Domain 1, it refers to leadership by the board of directors, trustees, and corporate and senior managers.

Patient—The individual recipient of care—that is, the patient, client, legal surrogate, or person.

Primary written and spoken language—The self-selected language the patient wishes to use to communicate with his or her healthcare provider.

Title VI of the Federal Civil Rights Act of 1964 (US DHHS Office of Civil Rights, 2003) prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than services provided to other persons.

Threshold language— Title VI of the Federal Civil Rights Act of 1964 (US DHHS Office of Civil Rights, 2003) prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than services provided to other persons. In practice, this means that recipients of federal funds must facilitate equal access to services for LEP persons through the provision of language assistance, at no cost to service recipients. In response to the Title VI requirements, several state-level public health and mental health authorities have instituted “threshold language” policies (these can vary from state to state). Generally, these policies specify a number or proportion of individuals whose primary language is other than English that, when exceeded, mandates the implementation of measures that facilitate access to health and social services in a beneficiary’s primary language. For example, Title 9 of the California Code of Regulations, Section 1810.410, addresses the Cultural and Linguistic Requirements of the public mental health systems in California. Section 1810.410(f) defines threshold language as a primary language spoken by 3,000 people, or 5 percent of the beneficiary population, whichever is lower in an identified geographic area.

Organization Information

Dear Survey User,

Please complete provide the information below. If your organization is part of a larger healthcare system, you should respond to this survey for your individual organization only. Your responses should reflect the status and information pertaining only to this organization, as identified.

11. Organization Marketing Name:_____

12. Main phone number:_____

13. Type of Organization:
    a. ☐ Hospital
    b. ☐ Federally Qualified Health Center
    c. ☐Community Clinic
    d. ☐ Dialysis Facility
    e. ☐ Integrated Health System
    f. ☐ Commercial Health Plan
    g. ☐ Medicare Health Plan
    h. ☐ Medicaid Health Plan
    i. ☐ Other (Please specify:_____
    _____)

14. Is this organization part of a larger healthcare system?_____

15. IF YES TO PREVIOUS QUESTION: Please enter the name of the healthcare system:

_____

16. Name of Chief Executive Officer:

_____

17. Name of the person completing this survey: _____

18. Contact's title: _____

19. Contact's telephone number: _____

20. Contact's email address: _____

Domain 1: Leadership
Sub domain 1.2: *Commitment to Serving a Diverse Population*
Preferred Practice 3*
(Please refer to page 12 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies, activities or practices that an organization can implement or adopt in order to ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization and that this is coupled with an actionable plan. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	Has your organization: 1. Reviewed the organization's vision statement, goals, and mission to ensure they reflect a commitment to culturally competent care? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACCOUNTABILITY	Has your organization: 2. Provided staff members with the opportunity to provide input and comment on the action plan for providing culturally competent care? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 3. Made the vision statement, goals, mission, and the action plan for providing culturally competent care publicly available throughout the organization and the community? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ABILITY	Has your organization: 4. Developed and/or revised the organization's vision statement, goals, and mission to ensure it reflects a commitment to providing high quality, culturally competent care for diverse populations? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 5. Developed an action plan that includes explicit expectations and measureable objectives relating to culturally competent care? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACTION	Has your organization: 6. Implemented or updated the action plan for providing high quality, culturally competent care to the diverse populations your organization serves? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

To review implementation examples for practice 3, see p. C3 in Appendix C. Implementation Examples Cross-Walked to Practices in *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report

Domain 1: Leadership
Sub domain 1.3: Leadership Diversity
Preferred Practice 4
(Please refer to page 13 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies, activities or practices that an organization can implement or adopt in order to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the service area. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	Has your organization: 1. Reviewed the strategies for staff recruitment and selection processes to assess whether staff <u>at all levels</u> of the organization reflect the demographic characteristics of the service area? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACCOUNTABILITY	Has your organization: 2. Ensured that staff recruitment and selection processes focus on meeting the needs of the organization's goals for culturally competent care? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 3. Sought input from community leaders on strategies to recruit, retain, and promote staff <u>at all levels</u> of the organization (including upper management) from the community? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ABILITY	Has your organization: 4. Used a committee of current diverse staff to develop strategies for recruitment, retention, and promotion of staff that reflect the community <u>at all levels</u> of the organization (including upper management)? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 5. Conducted an **internal** assessment on how to address the need for staff diversity <u>at all levels</u> of the organization, including upper management? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 6. Conducted an **external** assessment on how to address the need for staff diversity <u>at all levels</u> of the organization, including upper management? (This can include obtaining data on the demographic characteristics of the service area and comparing it to diversity of staff.) ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ACTION	Has your organization: 7. Developed or implemented strategies for recruiting, retaining, and promoting a diverse staff <u>at all levels</u> of the organization**,** including upper management? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 8. Advertised and recruited from the community served? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

Domain 1: Leadership
Sub domain 1.4: Dedicated Staff and Resources
Preferred Practice 5
(Please refer to page 15 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies, activities or practices that an organization can implement or adopt in order to ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	Have your organization's Leaders: 1. Consulted with the care setting managers, clinical leaders, language service providers, and others to identify needed fiscal resources to appropriately meet the cultural needs of patients? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 2. Consulted with the care setting managers, clinical leaders, language service providers, and others to identify needed human resources to appropriately meet the cultural needs of patients? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACCOUNTABILITY	Has your organization: 3. Documented where the <u>fiscal support</u> for culturally competent policies and practices is within the organization? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ABILITY	Has your organization: 4. Established and enforced organizational policies that support the allocation of fiscal resources for cultural competency? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 5. Ensured that there are budget line items and specific allocations for cultural competency activities and programs that reflect the organization's goals for providing culturally competent care? ☐ Yes ☐ No 6. Provided staff with time and resources for training programs and practices that promote culturally competent care? *(Check all that apply)* ☐ Yes, for physicians (including staff and/or non-staff physicians) ☐ Yes, for other clinical staff ☐ Yes, for non-clinical staff that has patient contact ☐ No
ACTION	Has your organization: 7. Provided training and coaching on culturally competent care to **new** staff? *(Check all that apply)* ☐ Yes, for physicians (including staff and/or non-staff physicians) ☐ Yes, for other clinical staff ☐ Yes, for non-clinical staff that has patient contact ☐ No 8. Provided continued training and coaching on culturally competent care to **current** staff? *(Check all that apply)* ☐ Yes, for physicians (including staff and/or non-staff physicians) ☐ Yes, for other clinical staff ☐ Yes, for non-clinical staff that has patient contact ☐ No

Domain 2: Integration into the Management System and Operations
Sub domain 2.1: Strategic Planning
Preferred Practice 8
(Please refer to page 16 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies; activities or practices that an organization can implement or adopt in order to integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	Has your organization: 1. Reviewed the organizational strategic plan to ensure that it has clear goals that include providing culturally competent services? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACCOUNTABILITY	Has your organization: 2. Involved consumers and the community served in the development of a strategic plan that has clear goals that include providing culturally competent services? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 3. Involved staff in the development of a strategic plan that has clear goals that include providing culturally competent services? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ABILITY	Has your organization: 4. Gathered data on community needs to inform the development and refinement of goals, plans, and policies for providing culturally competent care as part of the organizational strategic plan? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 5. Conducted an organizational self-assessment to inform the development and refinement of goals, plans, and policies for providing culturally competent care as part of the organizational strategic plan? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACTION	Has your organization: 6. Used results from the community needs assessment and self assessment processes to inform the development and refinement of goals, plans, and policies for providing culturally competent care as part of the organizational strategic plan? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

Domain 2: Integration in to the Management System and Operations
Sub domain 2.4: Reward Systems
Preferred Practice 10*
(Please refer to page 17 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies, activities or practices that an organization can implement or adopt in order to implement reward and recognition programs to recognize specific individuals, initiatives, and programs within the organization that promote cultural competency. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	Has your organization: 1. Reviewed job performance evaluation criteria to assess staff to ensure they include specific improvement goals related to cultural competence? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 2. Reviewed evaluation criteria used to assess initiatives and programs within the organization that promote cultural competence? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ACCOUNTABILITY	Has your organization: 3. Compared job performance evaluation criteria that include aspects of cultural competence with other recognition activities and awards to make sure they are on equal par? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 4. Compared evaluation criteria to assess initiatives and programs that promote cultural competence with other recognition activities and awards to make sure they are on equal par? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ABILITY	Has your organization: 5. Established standardized evaluation criteria that include aspects of cultural competence to assess **individuals** within the organization who promote cultural competency? ☐ Yes ☐ No 6. Established standardized evaluation criteria that include aspects of cultural competence to assess **initiatives and programs** within the organization that promote cultural competency? ☐ Yes ☐ No

ACTION	Has your organization: 7. Rewarded or recognized **individuals** within the organization who improve cultural competency and reduce health care disparities or who go beyond the preferred practices included in the Framework and Preferred Practices for Measuring and Reporting on Cultural Competency? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 8. Rewarded or recognized **initiatives or programs** within the organization that improve cultural competency and reduce health care disparities or that go beyond the preferred practices included in the Framework and Preferred Practices for Measuring and Reporting on Cultural Competency? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

To review implementation examples for practice 10, see p. C4 in Appendix C. Implementation Examples Cross-Walked to Practices in *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report

Domain 3: Patient-Provider Communication
Sub domain 3.1: Language Access
Preferred Practice 12
(Please refer to page 18 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies, activities or practices that an organization can implement or adopt in order to offer and provide language access resources in the patient's primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	Has your organization: 1. Reviewed its language assistance resource policies to ensure that your organization is providing language assistance to LEP persons at no cost to them? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 2. Reviewed language assistance services available in different areas of the organization? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 3. Reviewed wait times for language assistance services available in different areas of the organization? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ACCOUNTABILITY	Has your organization (or another organization if you use an outside language assistance vendor to provide interpreter services): 4. Evaluated the **qualifications** of all staff providing interpreting services or care directly provided in another language to patients? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 5. Assessed the **competency** of all staff providing interpreting services or care directly provided in another language to patients? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 6. **Monitored** all staff providing interpreting services or care directly provided in another language to patients to determine competency to provide services in healthcare settings? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ABILITY	Has your organization: 7. Created uniform procedures for timely and effective telephone communication between staff and LEP patients? ☐Yes ☐ No

ACTION

Has your organization:

8. Informed LEP individuals—**in their primary language**—that they have the right to free language assistance services and that such services are readily available?

   ☐ No
   ☐ Yes, within the last 12 months
   ☐ Yes, in the last 13-24 months
   ☐ Yes, in the last 25-36 months
   ☐ Yes, more than 36 months ago

9. Distributed, **at points of contact**, written notices with information informing patients that they have the right to free language assistance services and that such services are readily available?

   ☐ No
   ☐ Yes, at some but not all points of contact
   ☐ Yes, at most but not all points of contact
   ☐ Yes, at all points of contact

10. Used language identification or "I speak..." cards to inform patients that they have the right to free language assistance services and that such services are readily available?

    ☐ No
    ☐ Yes, within the last 12 months
    ☐ Yes, in the last 13-24 months
    ☐ Yes, in the last 25-36 months
    ☐ Yes, more than 36 months ago

11. Posted translated signage **at points of entry** in regularly encountered languages that language assistance services are available free of charge?

    ☐ No
    ☐ Yes, at some but not all points of entry
    ☐ Yes, at most but not all points of entry
    ☐ Yes, at all points of entry

12. Distributed to the public brochures, booklets, outreach materials, and other materials in regularly encountered non-English languages that include statements about the language assistance services available and the right to free language assistance services?

    ☐ No
    ☐ Yes, within the last 12 months
    ☐ Yes, in the last 13-24 months
    ☐ Yes, in the last 25-36 months
    ☐ Yes, more than 36 months ago

ACTION	13. Provided qualified language resources including competent interpreters (staff, contractors from outside agencies, remote telephonic or video interpreting services, or credentialed volunteers) and/or bilingual/multilingual clinical staff for clinical encounters ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 14. Provided bilingual/multilingual general staff as navigators for other encounters (e.g., to assist in making appointments, assist with transfers within a facility) ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

Domain 4: Care Delivery and Supporting Mechanisms
Sub domain 4.1: Clinical Encounter
Preferred Practice 23
(Please refer to page 20 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies, activities or practices that an organization can implement or adopt in order to develop and implement a comprehensive care plan that addresses cultural concerns. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	**Within the past 12 months**, how often has your organization: 1. Reviewed patient care plans provided to patients to ensure that they address the physical, cultural, and social needs of the patient, including cultural background, religion, and spiritual belief system? ☐ Never ☐ Sometimes ☐ Usually ☐ Always
ACCOUNTABILITY	**Within the past 12 months**, has your organization: 2. Developed a comprehensive care plan with patients and their caregivers to ensure that the plan addresses the physical, cultural, and social needs of the patient, including cultural background, religion, and spiritual belief system? ☐ Yes, for some patients (for example, high risk patients) ☐ Yes, for all patients ☐ No

ABILITY	**Within the past 12 months**, how often has your organization: 3. Collected information on patients' and families' primary written and spoken languages and any cultural beliefs that might affect the care plan, **including but not limited to** those involving spirituality/religion, nation of origin, and ethnicity? ☐ Never ☐ Sometimes ☐ Usually ☐ Always
ACTION	**Within the past 12 months**, has your organization: 4. Implemented comprehensive care plans that address the physical, cultural, and social needs of the patient, including cultural background, religion, and spiritual belief system? ☐ Yes, for some patients (for example, high risk patients) ☐ Yes, for all patients ☐ No

Domain 5: Workforce Diversity and Training
Sub domain 5.2: Training Commitment and Content
Preferred Practice 30
(Please refer to page 21 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies, activities or practices that an organization can implement or adopt in order to implement training that builds a workforce that is able to address the cultural needs of patients and provide appropriate and effective services as required by federal, state, and local laws, regulations, and organizational policies. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	Has your organization: 2. Reviewed training materials and programs used to provide cultural competence training? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 2. Assessed the organization's progress in recruiting, hiring, and retaining qualified, diverse staff at all levels of the organization? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ACCOUNTABILITY	Has your organization: 3. Evaluated cultural competence training programs to ensure that managers and staff at all levels of the organization receive training that is effective, relevant, and up to date? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 4. Had human resource managers assess the qualifications and competency of staff responsible for cultural competency training? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 5. Had human resource managers assess and report on employee promotions, terminations, and resignations to evaluate how well the organization is doing in the promotion and retention of a diverse workforce? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ABILITY	Has your organization: 6. Developed or updated training materials or programs to increase staff awareness of the cultural needs, beliefs, and attitudes of the predominant populations served by the organization? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 7. Included or updated training materials or programs to provide staff in-depth information about the causes of and research on cultural competency, inequities, and healthcare disparities? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 8. Provided staff with time and resources for training programs and practices that promote culturally competent care? *(Check all that apply)* ☐ Yes, for physicians (including staff and/or non-staff physicians) ☐ Yes, for other clinical staff ☐ Yes, for non-clinical staff that have patient contact ☐ No

ACTION	Has your organization: 9. Provided training and coaching to **new** staff to increase cultural competency awareness, knowledge, and skills? *(Check all that apply)* ☐ Yes, for physicians (including staff and/or non-staff physicians) ☐ Yes, for other clinical staff ☐ Yes, for non-clinical staff that have patient contact ☐ No 10. Provided training and coaching to **current** staff to increase cultural competency awareness, knowledge, and skills?? *(Check all that apply)* ☐ Yes, for physicians (including staff and/or non-staff physicians) ☐ Yes, for other clinical staff ☐ Yes, for non-clinical staff that have patient contact ☐ No

Domain 6: Community Engagement
Sub domain 6.1: Community Outreach
Preferred Practice 32*
(Please refer to page 32 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies, activities or practices that an organization can implement or adopt in order to collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health care disparities, and equity in the community. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	Has your organization: 1. Identified resources in the community to develop training programs, research projects, and outreach activities to help understand and address the cultural needs of the communities served? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACCOUNTABILITY	Has your organization: 2. Created a community advisory board that is representative of the diverse community served by the organization? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ABILITY	Has your organization: 3. Established or maintained collaborative relationships with community organizations to help understand and address the cultural needs of the communities served? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACTION	Has your organization: 4. Worked with community organizations on specific health education programs to raise awareness about local healthcare services? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 5. Utilized community experience and resources to develop training programs, research projects, or outreach activities to address the needs of culturally diverse populations, or to address health care disparities and equity in the community? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

To review implementation examples for practice 32, see p. C10 in Appendix C. Implementation Examples Cross-Walked to Practices in *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report

Domain 7: Data Collection, Public Accountability, and Quality Improvement
Sub domain 7.1: Collection of Patient Cultural Competency-Related Information
Preferred Practice 37
(Please refer to page 23 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies, activities or practices that an organization can implement or adopt in order to ensure that, at a minimum, data on an individual patient's race and ethnicity (using the Office of Management and Budget [OMB] categories as modified by HRET) and primary written and spoken language are collected in health records and integrated into the organization's management information systems. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	Has your organization: 1. Reviewed patient data on race/ethnicity to ensure that you are collecting this information using OMB categories as modified by HRET231? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 2. Reviewed data from **health records** to ensure that data on an individual patient's race and ethnicity and primary written and spoken language are collected? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 3. Reviewed data from your organization's **management information system** to ensure data from patients' health records on an individual patient's race and ethnicity and primary written and spoken language are integrated into the management information systems? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ACCOUNTABILITY	Has your organization: 4. Reviewed policies and procedures to ensure that patients' race/ethnicity data is not used for discriminatory purposes? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ABILITY	Has your organization: 5. Developed, maintained or improved the process for **collecting** data on an individual patient's race and ethnicity and primary written and spoken language in the patient's **health record**? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 6. Developed, maintained or improved the process for **integrating** data on an individual patient's race and ethnicity and primary written and spoken language into **management information systems**? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACTION	Has your organization: 7. Updated information on patients' race and ethnicity and primary written and spoken language in **the last 12 months**? ☐ No ☐ Yes, updated in the health record only ☐ Yes, updated in the health record and the management information system

Domain 7: Data Collection, Public Accountability, and Quality Improvement
Sub domain 7.3: Quality Improvement
Practice Statement 40
(Please refer to page 24 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies, activities or practices that an organization can implement or adopt in order to apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity, and primary written and spoken language information collected by the institution. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	Has your organization: 1. Identified NQF-endorsed performance measures to collect and use for quality improvement activities focused on providing more culturally competent care and discovering and eliminating health care disparities in access, outcomes, or patient experiences with care? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACCOUNTABILITY	Has your organization: 2. Based on national benchmarks, set organizational targets and benchmarks for performance measures? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ABILITY	Has your organization: 3. Utilized performance improvement methodology and science such as rapid cycle change and Plan-Do-Study-Act cycles to implement quality improvement activities focused on providing more culturally competent care and eliminating health care disparities in access, outcomes, or patient experiences with care? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 4. Used information on patients' race, ethnicity, and primary written and spoken language to design and/or inform quality improvement strategies and projects focused on providing more culturally competent care and eliminating health care disparities in access, outcomes, or patient experiences with care? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACTION	Has your organization: 5. Implemented quality improvement strategies or projects focused on providing more culturally competent care and eliminating health care disparities in access, outcomes, or patient experiences with care? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

Domain 7: Data Collection, Public Accountability, and Quality Improvement
Sub domain 7.5: Assessment of Patient Experiences with Care
Preferred Practice 43*
(Please refer to page 25 of the Guidance Document for additional information about this practice)

The following questions collect information on strategies, activities or practices that an organization can implement or adopt in order to assess and improve patient- and family-centered communication on an ongoing basis. Please indicate which of the following activities or practices your organization has engaged in or has implemented.

AWARENESS	Within the past 12 months, has your organization: 1. Collected information on model health care programs that use patient- and family-centered communication? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 2. Conducted site visits to successful health care programs that use patient- and family-centered communication? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 3. Consulted published guides on improving patient-provider communication? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ACCOUNTABILITY	Has your organization: 4. Utilized focus groups or patient surveys in the patient's **preferred** language, to collect data on patient experience of care as it relates to patient-provider communication? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 5. Collected data or sought input from staff on patient and family communication needs and performance? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 6. Utilized a patient survey to collect patient experience of care data that is being publicly reported either by your organization or by another organization? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

ABILITY	Has your organization: 7. Designed communication initiatives based on the needs of patients, families, and staff? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 8. Used champions to build support for new communication initiatives by presenting qualitative and quantitative data on patient and family communication needs and staff performance? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago
ACTION	Has your organization: 9. Implemented communication initiatives designed to improve patient and family-centered communication? ☐ No ☐ Yes, within the last 12 months ☐ Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago 10. Utilized findings from patient focus groups or patient surveys to assess whether patients and their families find that patient-provider communication is effective? ☐ No ☐ Yes, within the last 12 months ☐Yes, in the last 13-24 months ☐ Yes, in the last 25-36 months ☐ Yes, more than 36 months ago

To review implementation examples for practice 43, see p. C12 in Appendix C. Implementation Examples Cross-Walked to Practices in *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report

Affirmation of Accuracy

The statements and responses provided for our organization as part of the **Cultural Competency Implementation Survey** are accurate and reflect the current normal operating circumstances at our organization. I am authorized to provide these responses on behalf of our organization.

Affirmed by (print first and last name):_____

Title (enter title) _____

Signature:_____

Date:_____

Thank you for completing this survey. We appreciate your time and cooperation. In the next few weeks, you will receive a letter with your total survey score as well as your score on each of the practices covered by the survey. In addition, we would like to send you a $50 dollar gift certificate to Amazon to thank you for your participation.

Please indicate whether you would like to receive the $50 gift card or not:

☐ I would like to receive the $50 gift card
☐ Please do not send the $50 gift card

Would you like to receive a brief summary of the results of this study?

☐ Yes
☐ No

About how much time was required to complete the survey?

Enter total number of minutes: _____

Please provide any other information you think would be useful in helping us understand your survey responses or any comments you have about the survey:

_____

_____

_____

_____

_____

_____

_____

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THE SURVEY!

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K. Cultural Competency Implementation Survey Guidance Documentation (Final Version)

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Cultural Competency Implementation Survey

Guidance Documentation

Version 1.6
December 20, 2011

ACKNOWLEDGMENTS

These specifications were prepared under contract to the
National Quality Forum by:

RAND Corporation
1776 Main Street
Santa Monica, CA 90401
Questions related to the development or use of this survey measure should be sent to Beverly Weidmer at Beverly_Weidmer@rand.org.

Table of Contents

Survey Background and Overview

Racial and ethnic disparities in care are well documented and indicate that minority populations tend to receive lower quality of care even when factors such as access, health insurance, and income are taken into account. One major contributor to healthcare disparities is a lack of culturally competent care which can be defined as the ongoing capacity of healthcare systems, organizations, and professionals to provide diverse populations high quality care that is safe, patient and family centered, evidence based, and equitable. Providing culturally appropriate care is essential to reducing disparities and has the potential to improve outcomes while also creating greater patient satisfaction and helping increase the efficiency of clinical and support staff.

The National Quality Forum (NQF) is a private, nonprofit membership organization committed to improving healthcare quality for all Americans. NQF has become a recognized consensus standards-setting organization working with a diverse range of stakeholders to influence the U.S. healthcare system by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and reporting publicly on healthcare quality performance, and facilitating the attainment of national goals through education and outreach programs. NQF recently completed an extensive project endorsing a framework and a set of 45 preferred practices for measuring and reporting cultural competency. The preferred practices endorsed as part of this project were identified through an extensive literature review and with input from national subject matter experts and researchers in collaboration with NQF. This project set a foundation for improving care and established guidance for providing culturally competent healthcare services, reducing disparities, and making care more patient centered. The framework and preferred practices identified through this project can be found in a report titled *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency*. Based on this foundational work, NQF, with the help of a small multi-stakeholder expert panel, identified the need to develop a survey that can be used to assess an organizations' implementation of a core set of the preferred practices.

Purpose of the Survey

The *Cultural Competency Implementation Survey* is designed to collect information on adherence to a subset of the NQF-endorsed® cultural competency practices and to assist healthcare organizations in identifying the degree to which they are providing culturally competent care. The survey will serve as a resource for an organizational assessment of services provided for culturally diverse populations and adherence to NQF-endorsed® cultural competency practices. The results of the survey may be used by healthcare organizations to identify areas for quality improvement and by NQF to recognize healthcare organizations that have adopted the preferred practices for providing culturally competent care.

Survey Overview

The design of the *Cultural Competency Implementation Survey* is closely aligned with the cultural competency framework and preferred practices described in NQF's *Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency*. This document is the foundation for the development of the

survey measure along with the recommendations made by the NQF Expert Panel. The Expert Panel identified the recommended conceptual structure of the survey measures, the practices that should be included (12 of the 45 cultural competency practices covering the 7 domains of the framework), and the weighting practices and specifications to be used when determining the scoring of the survey measure.

The survey is designed as a single measure intended to be applicable across all settings of care. Individual survey measures are designed to be easy to understand, actionable, not subject to varied interpretations from organization to organization and from healthcare setting to healthcare setting, and able to stand on their own without requiring explanations from an interviewer. The survey uses the 4 A Adoption Framework (Developed by C. Denham of TMIT in 2001) in formulating the survey questions designed to assess an organization's adoption of a preferred practice. This framework allows one to define dimensions of progress in providing culturally competent care using the following concepts:

- Awareness: Refers to whether an organization has awareness of performance gaps related to a particular preferred practice and/or is aware of issues necessary for the adoption or improvement of a preferred practice;
- Accountability: Refers to whether the organization creates an environment or collects information to inform and/or improve performance;
- Ability: Refers to whether the organization has the ability or the information, or creates the environment to adopt or implement new practices or improve existing ones;
- Action: Refers to whether the organization engages in sustained action that is measurable both by process measures as well as outcome measures that clearly tie to closing performance gaps.

Survey questions are grouped along these four "dimensions of progress" which will allow the survey results to describe where an organization is in terms of implementing or adopting any one of the preferred practices covered in the survey.

Scoring Methodology

The Cultural Competency Implementation Survey measures organization's progress on 12 of the NQF-endorsed® cultural competency practices. Each practice is assigned an individual weight, which is factored into the overall score. Organizations will be ranked by quartiles based on their relative progress out of the total number of possible points on the survey.

Scoring of the NQF Practices

The NQF Expert Panel recommended that the 12 practices within the core set identified for the *Cultural Competency Implementation Survey* should be weighted differently for purposes of scoring. Each of the 12 practices has a maximum number of points based on the relative impact of the cultural competency practice. Below, we provide an overview of the maximum number of points for each of the practices covered by the survey. The maximum number of points for all practices is 142.

Domain	Subdomain	Practice Number	Weighting (pts)
Domain 3: Patient-Provider Communication	Language Access	12	19
Domain 1: Leadership	Dedicated Staff and Resources	5	17
Domain 1: Leadership	Leadership Diversity	4	14
Domain 1: Leadership	Commitment to Serving A Diverse Population	3	13
Domain 5: Workforce Diversity and Training	Training Commitment and Content	30	11
Domain 6: Community Engagement	Community Outreach	32	11
Domain 7: Data Collection, Public Accountability, and Quality Improvement	Quality Improvement	40	12
Domain 4: Care Delivery and Supporting Mechanisms	Clinical Encounter	23	10
Domain 7: Data Collection, Public Accountability, and Quality Improvement	Collection of Patient Cultural Competency-Related Information	37	11
Domain 7: Data Collection, Public Accountability, and Quality Improvement	Assessment of Patient Experiences with Care	43	11
Domain 2: Integration into Management Systems and Operations	Strategic Planning	8	8
Domain 2: Integration into Management Systems and Operations	Reward Systems	10	5
		TOTAL POINTS	142

Overall Points

The overall score for a survey is the sum of all the points earned for each cultural competency practice included in the survey. The sum of the points earned across all practices in the survey is multiplied by the ratio of 142 maximum points to the sum of available points for each practice.

Final Scoring

All organizations that complete a survey will be stratified into quartiles based on their overall points. In order to receive the highest level of recognition, an organization must be in the top quartile of responding organizations in terms of their overall points.

Public Reporting

The Cultural Competency Implementation Survey is being fielded for the first time in October 2011. The results of this first wave of data collection will **not** be publicly reported. Organizations that take part in the survey will receive their total survey score, their score by domain and by practice, the quartile they fell into, and when possible, information on how they scored compared to other participating organizations and to their peer group. However, neither RAND nor NQF will publicly report survey scores for any of the participating organizations nor will they publicly report any information that could be used to identify any of the participating organizations. The results of the 2011 survey will be evaluated by NQF, by the NQF expert panel and by the RAND Corporation and will inform a strategy for publicly reporting survey results going forward.

How to Access the Survey

The survey is available as an on-line survey. To access the survey, please go to https://www.randsurvey.org/ccis/. Participating organizations will receive a letter from RAND with instructions for accessing the survey.

Who should complete the survey?

The survey requires a variety of information and as a result one person may not have all the information to complete the survey on his/her own. We recommend that you print the survey (or complete the survey included in this document), review it, and then assign the survey completion to others in your organization as appropriate. Once the survey has been completed in hardcopy form, the organization's Chief Executive Officer (CEO) or his/her designated respondent can complete the survey online with the hardcopy of the survey in hand. Please note that the survey respondent must be authorized to complete the survey by the organization's CEO and the person responsible for completing and/or submitting the survey must attest to the accuracy of the information provided upon completing the survey.

How to Complete the Survey
In order to complete the survey, please follow the steps outlined below:

1. Please review this document (*Cultural Competency Implementation Survey Guidance Documentation*) before you start completing the survey. You may also want to refer to NQF's *Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency Report* as you complete the survey. These documents contain key information that helps clarify the survey questions and cultural competency practices covered by the survey.

2. The survey is available as a web survey but we recommend that you complete the survey off-line and then enter your responses over the web. This will speed the online completion of the survey and avoid the survey "timing out" after about 30 minutes of idle time (a security precaution). Please note that you can print off the PDF version of the survey from the survey's web page.

3. Once you complete the hardcopy of the survey, please submit your responses to the survey questions on-line by going to: https://www.randsurvey.org/ccis/ and entering your personal PIN number (provided in the invitation letter that was mailed to you along with this document).

4. If you prefer to mail your hard copy survey back, please mail to:

   NQF Cultural Competency Implementation Survey
   RAND-Corporation
   1776 Main Street
   PO Box 2138
   Santa Monica, CA 90407-2138

   Attention: David Coleman.

Completing parts of the survey in different online sessions
You may complete the on-line survey in different sessions. Just remember to save your responses and to log back in later to complete any pending questions. When you log back in, you will be taken back to the last unanswered question. Once you have completed all survey questions, you will be asked to affirm the entire survey before submitting your organization's survey.

Deadline for Completing the Survey
Please complete and submit your survey by **November 8, 2011.** If you will not be able to complete the survey by the deadline but would still like to participate in the survey, please let Beverly Weidmer know at Beverly weidmer@rand.org

Information and Technical Support
If you need any help or have any questions or comments about the survey, you may contact Beverly Weidmer at 310-393-0411 ext. 6788 or at Beverly weidmer@rand.org. For any technical questions or support in accessing the survey, you may email: nqfsurvey@rand.org.

Cultural Competency Implementation Survey

Overview of the Preferred Practices, Practice Specifications, and Concept Measures

The guidance documentation provided here includes information on the domain and sub domain for each of the preferred practices covered in the survey, the practice statement describing the practice, a series of specifications that provide additional clarification, and where applicable, a reference to the implementation example for that practice found in the NQF report. In addition, there are a series of descriptions (referred to as concept measures) provided by the NQF Expert Panel that offer concrete examples of activities organizations can engage in or information that can be collected to increase awareness of performance gaps, enhance accountability for leadership related to a specific practice, provide the ability to adopt the practice, or act to adopt the practice.

Each question in the survey is designed to collect information on activities the organization has engaged in or information the organization has collected in order to implement, adopt or improve the preferred practice related to that survey question. Participating organizations are asked to provide a response for each question included in the survey, even if they are not working to adopt or implement one of the practices, if they don't know the answer to a question, or if they feel a particular practice does not apply to their organization.

Note: The web version of the survey includes a response option for "don't know" and "not applicable" for each question in the survey. In addition, if you have comments or observations you would like to make about the survey, the web based version of the survey will allow you to enter comments at the end of each survey section and once more at the end of the survey.

Each question in the survey includes a series of response options to describe whether an organization has engaged or adopted a particular practice and if so, when. If your organization performs a particular practice periodically or on an ongoing basis, please select the most recent time period when the activity took place (e.g. "yes, within the last 12 months). In addition, please enter a comment in the "comments" box at the end of each section of the survey to indicate that your organization engages in a particular activity on an ongoing or periodic basis.

Please note that once the responses to all survey questions are entered using the web-based survey, survey respondents will be asked to submit their survey. Once the survey has been submitted, you will no longer have access to the survey.

Glossary of Survey Terms

Below we provide the definition for a variety of terms used throughout the survey:

Health professional—Physicians, administrators, nurses, physical and occupational therapists, linguistic services providers, psychologist social workers, and others who provide care to a patient.

High-quality healthcare—Healthcare that is delivered in a safe, effective, patient-centered, timely, efficient, and equitable manner and that is state of the art and evidence based.

Leadership—In reference to Domain 1, it refers to leadership by the board of directors, trustees, and corporate and senior managers.

Patient—The individual recipient of care—that is, the patient, client, legal surrogate, or person.

Primary written and spoken language—The self-selected language the patient wishes to use to communicate with his or her healthcare provider.

Title VI of the Federal Civil Rights Act of 1964 (US DHHS Office of Civil Rights, 2003) prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than services provided to other persons.

Threshold language— Title VI of the Federal Civil Rights Act of 1964 (US DHHS Office of Civil Rights, 2003) prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than services provided to other persons. In practice, this means that recipients of federal funds must facilitate equal access to services for LEP persons through the provision of language assistance, at no cost to service recipients. In response to the Title VI requirements, several state-level public health and mental health authorities have instituted “threshold language” policies (these can vary from state to state). Generally, these policies specify a number or proportion of individuals whose primary language is other than English that, when exceeded, mandates the implementation of measures that facilitate access to health and social services in a beneficiary’s primary language. For example, Title 9 of the California Code of Regulations, Section 1810.410, addresses the Cultural and Linguistic Requirements of the public mental health systems in California. Section 1810.410(f) defines threshold language as a primary language spoken by 3,000 people, or 5 percent of the beneficiary population, whichever is lower in an identified geographic area.

Domain 1: Leadership

Sub domain 1.2: *Commitment to Serving a Diverse Population*

Preferred Practice 3:
Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.

Specifications:

- Make publicly available the vision, goals, and mission of the organization and the action plan for implementation, after ensuring that staff members have had the opportunity to provide input and comment.

- Update the action plan at least annually.

Measure Concepts
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Adopting an organizational plan that includes explicit expectations and measureable objectives relating to culturally competent care; the plan is adopted and endorsed by leadership and updated on an annual basis;

- Developing a vision statement that indicates a commitment to providing high quality, culturally competent care for diverse populations; and

- Making a vision statement available on the organization's website, as well as in common patient care and administrative areas.

- Organizational leadership (the organization's top management, governance board, executives, and policymakers) communicates commitment to culturally competent care throughout the organization and the community.

Domain 1: Leadership

Sub domain 1.3: *Leadership Diversity*

Preferred Practice 4:
Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the service area.

Specifications:

- Establish an internal mechanism for developing strategies that involve using a committee of current diverse staff for recruitment, retention, and promotion of staff that reflect the community at all levels of the organization (including upper management).
- Conduct internal and external assessments on how to address the need for staff diversity at all levels of the organization (including upper management).
- Engage with community leaders, and specifically target and recruit staff from the community served.
- Ensure that staff recruitment and selection processes focus on meeting the needs of the organization's goals for culturally competent care.

Measure Concepts:
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Obtaining demographic data on diversity in the community served and comparing data to diversity of staff;

- Conducting organizational assessments annually on the ethnicity, language, gender, and racial characteristics of staff, employees, and associates at all levels of the organization and targeting retention and recruitment of staff at all levels (including upper management positions) based on this information;

- Establishing organizational goals for recruitment of diverse leadership and staff at all levels of the organization (including clinical leaders, administrative leaders, and the governance board);

- Including measureable components of participation and development of individual knowledge regarding cultural competency in annual employee reviews; and

- Establishing a committee or task force to provide oversight on staff diversity, recruitment, retention, and strategic direction to facilitate change in the recruitment and retention of staff that reflect the community at all staff levels.

Other recommended activities or concepts:

- Develop or adopt human resource strategies aimed specifically at diversifying the leadership ranks at all levels of the organization (including upper management).
- Advertisements of available positions should reflect diverse recruitment methods and target underrepresented populations.
- Collect data (using various approaches including but not limited to exit interviews) to understand the reasons behind the high turnover among minorities.

Domain 1: Leadership

Sub domain 1.4: *Dedicated Staff and Resources*

Preferred Practice 5:
Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.

Specifications:

- Leaders must consult with the care setting managers, clinical leaders, language service providers, and others to identify needed fiscal and human resources to appropriately meet the cultural needs of patients. The demographic profile (see Domain 7) may help inform this process
- Leadership should provide staff, at all levels, with the available time and resources for training programs and practices that promote culturally competent care.
- Ensure that continued training and coaching on culturally competent care is available for new and current staff.
- Document where the fiscal support for these activities is within the organization.
- Ensure that there are budget line items and specific allocations for cultural competency activities and programs.
- Establish and enforce organizational policies that support the allocation of fiscal resources for cultural competency.

Proposed Measure Concepts:
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Organization provides and requires participation in orientation and ongoing training of staff on legal, accreditation, and policy requirements related to cultural competency;

- Fiscal and human resource allocation as evidenced by job, product, and service descriptions are to be associated with diversity and cultural competency capacity development; and

- Employee and staff development of annual objectives and goals includes a minimum number of hours related to cultural competence.

Domain 2: Integration into the Management System and Operations

Sub domain 2.1: *Strategic Planning*

Preferred Practice 8:
Integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services. (This preferred practice also relates to the Leadership sub domains of Policies and Commitment to Serving a Diverse Population and the Data Collection, Public Accountability, and Quality Improvement sub domains of Accountability and Performance Management Systems.)

Specifications:

- A strategic plan should be developed with the participation of consumers, community, and staff who can convey the needs and concerns of all communities and all parts of the organization affected.
- Any results from data gathering and self-assessment processes should inform the development and refinement of goals, plans, and policies.

Proposed Measure Concepts:
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Incorporating a written policy concerning the availability and accessibility of language services;
- Incorporating the ability to generate an equity report based on certain quality indicators related to cultural competency and diversity; and
- Providing cultural competence education and training at least annually to nursing and physician staff.

Other recommendations/concepts:

- Conduct an environmental scan and gather data on community and address improvements from community health assessments.
- Conduct an assessment of organizational assets for providing culturally competent care

Domain 2: Integration in to the Management System and Operations

Sub domain 2.4: *Reward Systems*

Preferred Practice 10:
Implement reward and recognition programs to recognize specific individuals, initiatives, and programs within the organization that promote cultural competency.

Specifications:

- Establish standardized evaluation criteria to assess individuals, initiatives, and programs on equal par with other recognition activities and awards.
- Reward individuals, initiatives, or programs that improve cultural competency and reduce health care disparities or that go beyond the preferred practices in this document.

Proposed Measure Concepts:
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Improving upon performance evaluations by including cultural diversity goals, demonstrated achievement toward goals, and behaviors that show knowledge of cultural awareness and diversity;

- Incorporating financial and operational incentives for accomplishment of quality improvement initiatives related to cultural competency; and

- Incorporating better reward incentives to recognize diversity champions, managers, and staff who achieve cultural diversity goals.

Other recommendations/activities:

- Including patient and family assessments of care into the staff performance evaluations.
- Quality improvement efforts should include an assessment of impact on culturally diverse populations.

Domain 3: Patient-Provider Communication

Sub domain 3.1: *Language Access*

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

Specifications:

- Language resources encompass competent interpreters (staff, contractors from outside agencies, remote telephonic or video interpreting services, or credentialed volunteers) and/or bilingual/multilingual clinical staff for clinical encounters, as well as bilingual/multilingual general staff as navigators for other encounters (e.g., to assist in making appointments, assist with transfers within a facility).
- All staff providing interpreting services or care directly provided in another language to patients should be qualified, assessed, and monitored to determine competency to provide services in healthcare settings.
- Timely access to interpreter services is particularly critical in certain service areas such as emergency departments.
- Title VI, at a minimum, should guide language access resource policies.
- LEP individuals should be informed—in their primary language—that they have the right to free language services and that such services are readily available.
- At all points of contact, healthcare organizations should distribute written notices with this information and post translated signage that language services are available free of charge.
- Patients should be explicitly asked about their primary written and spoken language, and the information should be noted in all records; the primary language of each patient is the language he or she feels most comfortable using in a clinical or nonclinical encounter.
- Informing patients about language assistance services should include one or more of the following efforts: 1) use language identification or "I speak..." cards; 2) post and maintain signs in regularly encountered languages at all points of entry; 3) create and use uniform procedures for timely and effective telephone communication between staff and LEP patients; and 4) include statements about the services available and the right to free language assistance services in appropriate non-English languages in brochures, booklets, outreach materials, and other materials that are routinely distributed to the public.

Proposed Measure Concepts:
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Collect data on percentage of patients, with language needs other than English, who receive language assistance services (multilingual provider who speaks that language, use of qualified healthcare interpreter, use of telephonic interpretation service, etc.);
- Collect data on percentage of staff who provide healthcare interpreting who are assessed for language proficiency in both English and the organization's target language(s) and trained in health interpreting ethics and standards of practice;
- Collect data on percentage of unique patients for whom language need is documented and who are provided notice of the right to free language assistance services;
- Collect data on average wait times for patients with language needs versus those without language needs; and
- Collect data on percentage of clinical staff who use a language other than English to communicate with patients and who are assessed for language proficiency in the target language(s).

Other recommendations/activities:

- Benchmark the measure concepts suggested.
- Utilize measures focused on patient experience, in addition to system-related issues,
- Utilize measures focused on documenting patient preferences and administration of language services (e.g., interpreter, bilingual provider, etc.).

Domain 4: Care Delivery and Supporting Mechanisms

Sub domain 4.1: Clinical Encounter

Preferred Practice 23:
Develop and implement a comprehensive care plan that addresses cultural concerns.

Specifications:

- The care plan should be developed with patients and their caregivers.
- The care plan should note patients' and families' primary written and spoken languages and any cultural beliefs that might affect the care plan, including but not limited to those involving spirituality/religion, nation of origin, and ethnicity.

Proposed Measure Concepts:
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Incorporating assessment tools to elicit culturally relevant information on health beliefs, behaviors, and practices;

- Developing comprehensive care plans that address the physical, cultural, and social needs of the patient, including cultural background, religion, and spiritual belief system; and

- Using referrals with community-based organizations, such as social service and religious organizations.

Other recommendations/activities:

- Care plans should address the cultural and social needs of the patient and should serve as a tool to assist providers with critical patient information.
- Proposed measure concepts important components that should be integrated into care plans to simplify the patient care process.
- Care plans should address the cultural and social needs of the patient and should serve as a tool to assist providers with critical patient information.

Domain 5: Workforce Diversity and Training

Sub domain 5.2: *Training Commitment and Content*

Preferred Practice 30:
Implement training that builds a workforce that is able to address the cultural needs of patients and provide appropriate and effective services as required by federal, state, and local laws, regulations, and organizational policies. (See also the Leadership sub domain of Policies.)

Specifications:

- Include in training materials information regarding in-depth knowledge about the causes of and research on cultural competency, inequities, and healthcare disparities.
- Also include material related to healthcare and treatment regarding understanding the different cultural beliefs and attitudes of the predominant populations served by the organization.
- Promote a system to recruit and retain qualified staff from diverse backgrounds that understand their patient cultures and communities, in order to support organizational cultures that can better serve communities.
- Provide training opportunities to increase cultural competency skills to assist staff with their responsibilities for direct patient care.
- Annually assess the organization's progress in recruiting, hiring, and retaining qualified bicultural/multicultural employees.
- Human resource managers should assess and report on employee promotions, terminations, and resignations, and should include the use of exit interviews, to evaluate how well the organization is doing in the promotion and retention of a diverse workforce.

Proposed Measure Concepts:
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Include organizational policies and procedures in human resources processes for addressing diversity and cultural competence issues;

- Expand staff training/continuing education to include patient demographics and diversity, cultural competence, language assistance, disability access, and spiritual needs; and

- Provide annual training to address the needs of cultures representing over a certain percentage of the population served.

Domain 6: Community Outreach

Sub domain 6.1: Community Outreach

Preferred Practice 32:
Collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, healthcare disparities, and equity in the community.

Specifications:

- Organizations should work closely with a community advisory board.
- Organizations should collaborate with community organizations, in particular for health education programs, where they can help to raise awareness about local healthcare services.
- Organizations should partner with the community on specific programs and draw on the experiences and resources in the community to develop training programs, research projects, and outreach activities.

Proposed Measure Concepts:
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Development of a community advisory board to provide recommendations for working with the community;
- Development of formal agreements (memoranda of understanding, contracts, etc.) to document collaborations with community-based organizations working with diverse patient populations;
- Development of formal referral and follow-up processes to and from the organization and community-based organizations working with diverse patient populations; and
- Development of a formal or informal mechanism to engage local community leaders (e.g., community advisory board, participation and attendance at community functions, etc.).

Other activities/recommendations:

- Critical to document collaborations with community-based organizations working with the diverse populations, as well as to acknowledge techniques used for formal referral, follow-up processes, and engagement of local community leaders from these organizations.

- Important use the concept of community engagement and not just engagement with leaders of organizations/institutions.

- Important to have organizations document their participation in community activities that address healthcare disparities and equity.

Domain 7: Data Collection, Public Accountability, and Quality Improvement

Sub domain 7.1: Collection of Patient Cultural Competency-Related Information

Preferred Practice 37:
Ensure that, at a minimum, data on an individual patient's race and ethnicity (using the Office of Management and Budget [OMB] categories as modified by HRET) and primary written and spoken language are collected in health records and integrated into the organization's management information systems. Periodically update the language information.

Specifications:

- Use the OMB categories as modified by HRET231: OMB Ethnicity: Hispanic or Latino; Not Hispanic or Latino
- OMB Race: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White
- HRET Modifications: Multiracial; Declined; Unavailable
- Update the information annually.
- Organizations should ensure by policies and procedures that no data are used for discriminatory purposes.

Proposed Measure Concepts:
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Ensuring race/ethnicity/language data elements exist in information systems;
- Ensuring data elements used for an electronic health record conform with OMB categories for race/ethnicity data and HRET for language data elements; and
- Developing a process to update language data elements.

Other activities/recommendations:

- Ensure that data collected on race/ethnicity/language is self-reported by the beneficiary.
- Set goals and establish mechanisms for reducing missing data on race/ethnicity/language
- Integrate data on race/ethnicity/language into a management system that supports clinical care.
- Integrate data on race/ethnicity/language into an organization's electronic health record

Domain 7: Data Collection, Public Accountability, and Quality Improvement

Sub domain 7.3: *Quality Improvement (7.3)*

Practice Statement 40:
Apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity, and primary written and spoken language information collected by the institution.

Specifications:

- Identify NQF-endorsed performance measures to collect and use for quality improvement.
- Based on national benchmarks, set organizational targets and benchmarks for performance measures.
- Utilize performance improvement methodology and science such as rapid cycle change and Plan-Do-Study-Act cycles.

Proposed Measure Concepts:
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Ensuring race/ethnicity/language data are used to identify disparities and aggregated and analyzed for disparities;
- Designing and implementing quality improvement strategies/projects, informed by race/ethnicity/language data to improve cultural competence and eliminate disparities; and
- Performing continuous assessment of goals and quality improvement projects/strategies and modifying them as needed.

Other activities/recommendations:

- Data collected on race/ethnicity and language could be used to identify disparities to target and inform an organization's quality improvement strategies.

Domain 7: Data Collection, Public Accountability, and Quality Improvement

Sub domain 7.5: *Assessment of Patient Experiences with Care*

Preferred Practice 43:
Assess and improve patient- and family-centered communication on an ongoing basis.

Specifications:

- Use the HRET-specified categories to collect the race, ethnicity, and primary written and spoken language of the respondents.
- The design and implementation of communication initiatives should assess the needs of patients, families, and staff.
- Data should be used to build support for initiatives; champions should build support for new communication initiatives by presenting qualitative and quantitative data on communication needs and performance.
- Information on model programs should be collected; site visits to successful programs should be conducted; and/or published guides should be consulted.
- At a minimum, annually utilize focus groups or patient surveys to assess whether patients and their families find that patient-provider communication is effective.

Proposed Measure Concepts:
The following measure concepts provide examples of activities an organization could engage in to adopt or improve the specifications described as part of this preferred practice.

- Use patient surveys (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS] Item Set to Address Health Literacy) and/or focus groups or other qualitative methods to assess patient- and family-centered communication at regular intervals, at least once a year; and
- Develop and implement quality improvement plan to improve patient- and family-centered communication. This could include providing individual level feedback, clinician and staff training, redesign of visit to be more conducive to patient- and family-centered communication, etc.

Notes:
- Organizations can use their own tools and resources such as the “Comment Box” to obtain patient feedback.

Cultural Competence Implementation Survey
Frequently Asked Questions

What is RAND?
The RAND Corporation is a private, not for profit research center based in Santa Monica, CA. RAND's mission is to conduct research on issues of public interest on a variety of topics including health care, the economy, the environment, education, etc.

What is NQF?
NQF is the National Quality Forum. It is a nonprofit organization committed to improving healthcare quality for all Americans.

What is the purpose of the Cultural Competency Implementation Study?
The purpose of the Cultural Competency Implementation study is to assess how health care organizations are doing implementing the core set of preferred practices and adhering to the NQF-endorsed cultural competency practices.

Who is participating in this survey?
The survey is being fielded for the first time in October 2011. The sample for the 2011 survey includes approximately 275 health care organizations in different settings of care such as hospitals, health plans, in-center dialysis clinics, and community clinics and health centers.

How long will this take?
The survey will take approximately 30-40 minutes to complete.

Do I have to complete the entire survey in one session?
No, you can complete the online survey in different sessions. Just remember to save your responses and log back in later to complete any pending questions.

Why should I participate?
We will send you a $50.00 gift card as a thank you for participating. Additionally, the survey will help your organization identify areas for quality improvement in the delivery of culturally competent care and services for diverse patient populations, provide valuable information on your organization's adherence to the NQF-endorsed cultural competency practices, and provide information on how your organization is doing in implementing, adopting, or improving the preferred practices covered in the survey, compared to other organizations that take part in the survey.

When does the survey need to be completed?
We hope you can complete the survey by **November 8, 2011**.

Will my organization receive the survey results?
Yes, we will provide each participating organization their total survey score, their score by practice, and if possible, information on how their organization scored in relation to other peer organizations that completed the survey. Please note that we will not make survey scores publicly available and that you will only have access to your own organization's score.

Who will be able to see my organization's data?
Only research staff from the RAND Corporation working directly on this project will have access to your organization's data.

Public Reporting
The Cultural Competency Implementation Survey is being fielded for the first time in October 2011. The results of this first wave of data collection will **not** be publicly reported in a way that can identify participating organizations. The results of the 2011 survey will be evaluated by NQF and the RAND Corporation and will inform a strategy for public reporting going forward.

Whom do I contact if I have questions about how to complete the survey or about participation in the survey?
If you have any questions, concerns or comments about the survey, please don't hesitate to contact Beverly Weidmer, Survey Director and Project PI, via email at Beverly_Weidmer@rand.org or by telephone at (310) 393-0411, ext. 6788.

THANK YOU FOR YOUR COOPERATION!