NATIONAL QUALITY FORUM

TO: Consensus Standards Approval Committee

FR: Nicole McElveen

RE: Voting Results for *Healthcare Disparities and Cultural Competency Consensus Standards*

DA: July 11-12, 2012

The CSAC will review recommendations from the project Healthcare Disparities and Cultural Competency Consensus Standards during the July 11-12 in-person meeting. This memo includes a list of the recommended measures, summary information about the project, and NQF Member voting results. The individual measure evaluation summary tables from the draft report are in the Appendix. The complete voting draft report and detailed measure information are available on the project webpage.

CSAC ACTION REQUIRED

Pursuant to the Consensus Development Process (CDP), the CSAC may consider approval of 12 candidate consensus standards as specified in the "voting draft" Healthcare Disparities and Cultural Competency Consensus Standards technical report.

BACKGROUND

The Healthcare Disparities and Cultural Competency Consensus Project consisted of two phases: (1) development of a commissioned paper focused on measurement issues for healthcare disparities, and (2) identifying performance measures for healthcare disparities and cultural competency. The commissioned paper and this project are specifically focused on healthcare disparities and cultural competency for racial and ethnic minority populations.

The commissioned paper on Healthcare Disparities Measurement, authored by The Disparities Solution Center at Massachusetts General Hospital, provided background context and recommendations to NQF in the following: selecting and evaluating disparity-sensitive quality measures, outlining the methodological issues with disparities measurement, and identifying cross-cutting measurement gaps in disparities. The paper served as a foundational document to assist the Healthcare Disparities and Cultural Competency Steering Committee with its recommendations on methodological concepts for disparities measurement and a protocol for identifying measures as disparities-sensitive.

PROCESS

This project followed the National Quality Forum's (NQF) version 1.9 of the CDP. The Steering Committee met in person on February 23-24, 2012 and reconvened via conference call on March 16, 2012, to continue evaluating the measures. The Committee met via conference call again on May 22, 2012, to address comments received during the NQF Member and public commenting period.

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Healthcare Disparities and Cultural Competency Measures Summary

	MAINTENANCE	NEW	TOTAL
Measures under consideration	0	16	16
Recommended	0	12	12
Not recommended	0	4	4
Reasons not recommended		2 – Importance to Measure and Report 2 – Scientific Acceptability of Measure Properties	

The measures were evaluated against the 2011 measure evaluation criteria. In the context of the commissioned paper, the Steering Committee discussed several concepts related to measurement and reporting related to disparities. In particular, following the comment period for the paper, several overarching issues were noted for further consideration. A summary of those comments/issues as they surfaced in the content of reviewing the measures is provided.

Additionally, during its evaluation of candidate consensus standards, the Committee identified other overarching issues. While the issues pertained at the time to one particular measure, they apply to the set of recommended measures as a whole. These issues were factored into the Committee's ratings and recommendations for multiple measures and are explained below.

Applicability of care setting

Measures that can be applied to multiple stakeholders should have a higher priority. Additionally, it is important to have uniform data standards to identify and resolve quality disparities across the healthcare sector and to track an organization's capacity for cultural and linguistic competency.

Alignment with national strategies around cultural competency and disparities

Measures should acknowledge and align with existing accreditation standards or national recommendations related to disparities and cultural competency; several were noted by the Committee, including the U.S. Department of Health and Human Services standards on culturally and linguistically appropriate services (CLAS), the Institute of Medicine recommendations for standardized collection of race/ethnicity data for healthcare quality improvement, and recommendations from the Joint Commission for advancing communication, cultural competence, and patient-centered care.

Public reporting and incentivizing measurement

While acknowledging the public reporting and quality payment climate that are now integral to healthcare quality, the Committee expressed concerns about the potential for unintended consequences if disparities-related public reporting or value-based purchasing is implemented without ensuring appropriate system design; the potential for inappropriate and unjust damage to the reputations of facilities and providers is of particular concern. In addition, attention should be given to the analytic recommendations on measuring healthcare disparities noted in the commissioned paper to avoid dismissal or mistrust of the results.

To address concerns about public reporting and disparities-related performance measurement, the Committee identified several approaches and recommendations to spotlight. (Additional recommendations are also noted in the commissioned paper.)

- Much greater attention to adjustment and/or stratification is needed when absolute performance on quality measures is used for public reporting and/or payment.
- Consider a window of data collection/reporting by providers or facilities prior to implementing any organized public reporting or pay-based incentives.
- Use payment for improvement versus payment to achieve quality benchmarks or thresholds. For example, use a mix of achievement (median), benchmark (90th percentile), and improvement thresholds.
- Pay for performance based on lower racial/ethnic disparities (versus paying for higher-quality performance applied generally to all patients).
- Conduct special studies that monitor for potential unintended consequences, such as increased difficulty accessing care or adverse financial impacts on safety net providers.
- Pay for performance based on improving quality of care for minority populations.
- Focus on quality improvement efforts that target safety net providers and providers with high numbers of minority patients, and direct supplemental resources to those providers for improving disparities and the sharing of best practices.
- Assess structural characteristics of providers until more evidence-based process and outcome measures are developed.
- Motivate providers to improve performance through the use of a consumer liaison to serve as a mediator between the community and providers/organizations to advocate incentivizing the patient toward better behavior modifications.

The Committee and the commissioned paper emphasize there is no single answer, nor a one-size-fits-all solution. Addressing public reporting for disparities should involve an incremental approach with the input of key stakeholders.

Indirect data collection
Although acknowledging that indirect collection of race/ethnicity data offers flexibility, the Steering Committee continues to recommend self-identified data as the preferred method for data collection and considers indirect estimation as a complementary technique in the short-term.

Principles for addressing disparities, quality improvement, and public reporting
Several principles presented in the commissioned paper were discussed and agreed on by the Committee to accelerate the advancement of healthcare equity and literacy:

- Support efforts that focus on translating scientific evidence into every day medical practice, and promote the identification and rapid adoption of best practices proven to reduce disparities;
- Invest more in research and the collection and analysis of clinical data (stratified by race, ethnicity, and language) where evidence is lacking, and ensure data are available at the local and state levels to more effectively translate research into action;
- Promote transparency of cost, outcomes, and patient experience through availability of timely, actionable, and culturally and linguistically appropriate information for patients

and providers; this includes standardization of consumer tools to allow the healthcare consumer greater ease in comparing across diverse populations; and

- View health equity as inclusive of gender, age, education, and other socioeconomic variables, in addition to race/ethnicity/language. (NQF, the Committee and commissioned paper note that the intention of this NQF project was not to exclude groups that demonstrate disparities, but rather to focus on racial/ethnic disparities as a starting point for measurement and reporting).

RELATED AND COMPETING MEASURES

The Committee was presented with the details and specifications for measure comparisons that address related concepts of health literacy and cultural competency.

Health Literacy:
1898 – Health Literacy measure of the C-CAT
1902 - Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
The similarities and differences between the specifications of these measures were reviewed and the Committee agreed both measures should be recommended for endorsement. The Committee justified this recommendation by noting that the measures included differences in the target populations, as well as different aspects of content covered by the questions in the specifications for each.

Cultural Competency:
1919 – Cultural Competency Implementation Measure
1894 – Cross-cultural measure of the C-CAT
1904 – Clinicians/Groups' Cultural Competence Based on the CAHPS Item Set for Addressing Cultural Competence
The Committee concluded that one difference and strength of the RAND Cultural Competency Implementation Measure (#1919) is the applicability in multiple care settings; it was noted that there is an absence of measures addressing cultural competency for other healthcare organizations, such as health plans. (The Communication Climate Assessment Toolkit (CCAT) is hospital-based.) The burden of implementing all three related measures by a single organization was noted, but it was clarified that an organization considering these measures for implementation can choose which measure to utilize depending on the measure's applicability to the organization's programs and services for measurement of cultural competency. Generally, the Committee agreed all three cultural competency measures should move forward for endorsement, but suggested including a statement within the project report that speaks to the overlap of the concepts between the measures.

COMMENTS ON THE DRAFT REPORT AND THEIR DISPOSITION

NQF received 70 comments from a variety of stakeholders, including 15 Member organizations and organizations and individuals on measures both recommended and not recommended for endorsement, as well as general comments on the draft report.

A table of all comments submitted during the comment period, with the responses to each comment and the actions taken by the Steering Committee, is posted to the Healthcare Disparities and Cultural Competency project page on the NQF website, along with the following additional information:

- Measure submission forms
- Meeting and call transcripts and recordings from the Committee's discussions

The comments include general comments or comments that address groups or classes of measures, as well as comments specific to individual measures. Comments related to specific measure specifications were forwarded to appropriate measure developers, who were invited to respond.

GENERAL COMMENTS

Harmonization

Several comments noted a lack of harmonization between the CCAT and CAHPS measures, specifically suggesting developing additional HCAHPS questions that could address the same issues of the CCAT, thereby making the feasibility of collecting data on cultural competency and disparities at the hospital level more efficient.

ACTION TAKEN: The similarities between the CCAT and CAHPS measures were discussed thoroughly by the Steering Committee, and it recommended both measures for endorsement for several reasons, in particular due to differences in target populations and content. The Steering Committee does, however, recommend the measures developers consider harmonization before the measures are considered again for maintenance in three years.

Stratification

A comment was received recommending a modification in the methods section of the report, specifically on the approach to stratification. The commenter requested that the Steering Committee consider a modification to the indicator of primary language, changing it to "limited English proficiency". The original recommendation reads – "Stratification by race/ethnicity and primary language should be performed when there are sufficient data to do so."

ACTION TAKEN: The Committee did not agree with the term "limited English proficiency" as the appropriate construct for stratification. Rather, the Committee decided to use the term "preferred language," which currently reflects the operative word to use; in addition, the term "primary language" is operationalized in many institutions as meaning preferred language for the healthcare encounter. The recommendation was revised to – "Stratification by race/ethnicity and preferred language should be performed when there are sufficient data to do so."

Collecting data on race/ethnicity/language
A comment was received expressing concern with how entities collect data on race and ethnicity, specifically whether is it collected through one question (e.g., race or ethnicity) or two question (e.g., race and ethnicity separately). The commenter raised the question as to whether this issue should be standardized across measure specifications from different developers.

ACTION TAKEN: The Steering Committee emphasized the Institute of Medicine (IOM) recommendations from the report - *Race, Ethnicity, and Language Data: Standardization for Healthcare Quality Improvement*. The IOM does not specify a particular question format for collecting race and ethnicity (i.e., one question vs. two questions), but rather recommends entities focus on completeness and accuracy of responses when collecting this data.

MEASURE-SPECIFIC COMMENTS

1902: Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy (AHRQ)

Several comments were received suggesting that the measure developers consider a reduction of the sampling time from 12 to 6 months, since patients with multiple chronic conditions may have a large array of providers and may therefore already have difficulty (which time would compound) in recalling an individual provider's efforts to improve their health literacy.

ACTION TAKEN: The measure developer responded with the following comment: "Choosing an appropriate recall period is indeed a challenge and the CAHPS Team has carefully considered this issue over the years of developing CAHPS surveys. It has determined that the 12-month recall period for the CAHPS Clinician and Group survey does the best job of balancing the challenge of remembering what transpired over the 12-month period and having enough experience with the clinician/group to capture care delivered over a period of time rather than a point in time. As you point out, for some populations who use health care services more frequently than average a shorter recall period might be more appropriate. For example, the CAHPS Health Plan surveys for Medicaid and Medicare beneficiaries use a 6-month recall period because it was found this period was the shortest for which beneficiaries would have sufficient plan experience to report on. These supplemental health literacy items, however, were designed to be used with the CAHPS Clinician and Group survey and have therefore only been tested for the 12-month recall period." The Committee also agreed with the rationale and comments provided from the measure developer.

1888: Workforce development measure derived from workforce development domain of the CCAT (AMA)

Several comments were received suggesting that the measure developers consider including data on: 1) the extent to which a facility's workforce reflects the demographic diversity of its patient population; and 2) the percentage of staff respondents who both receive cultural competency training and have direct patient contact. The commenter also suggested the measure developer consider whether it's feasible to incorporate a greater number of items from the C-CAT patient survey in the measure numerator, thus providing an improved basis for assessing the extent to which staff training enhances care.

ACTION TAKEN: The measure developer responded with the following comment: "Regarding the specific suggestions, data on the extent to which the facility's workforce reflects the demographic diversity of the patient population are collected in this measure through an item on the patient survey (Do hospital/clinic staff come from your community?) and an item on the staff survey (Have senior leaders worked to recruit employees that reflect the patient community?). In addition, sites using the CCAT receive data on the demographic composition of patient populations, patient respondents, staff populations and staff respondents, as well as extensive contextual information on organization policies and staff, patient and leadership responses to the key items that contribute to this measure score. Staff members are asked specifically about both their direct contact with patients as well as their cultural competency training and sites using the CCAT receive these stratified data. Finally, for sites that use the CCAT iteratively it would be possible to examine correlations between staff trainings and changes in other measure scores to determine whether a specific training affects performance." The Committee also agreed with the rationale and comments provided from the measure developer.

NQF MEMBER VOTING

The 15-day voting period for *Healthcare Disparities and Cultural Competency Consensus Standards* project concluded on June 20, 2012. Twenty Member organizations voted; no votes were received from the Supplier/Industry Council.

All 12 measures were approved with total approval ranging from 96% to 100%. Three Health Plan voters submitted comments on measures that were recommended, many of which were similar and previously addressed by the Steering Committee:

Measure #1888 Workforce development measures derived from workforce development domain of the Communication Climate Assessment Toolkit

Voter Comment: [*Submitted by* America's Health Insurance Plans] This measure is appropriate for provider-level measurement. Additional validation of CCAT tool similar to CAHPS testing is needed.

Voter Comment: [*Submitted by* Humana Inc.] Agree. Concern that the CCAT needs the degree of validation that CAHPS currently enjoys. The work group comments that this should work in the hospital.

Voter Comment: [*Submitted by* BCBSA] The measures identified cut across multiple audiences and setting. The CAHPS measures can have the greatest impact on health plans/payers; however, CCAT is more geared toward the practice setting. As such, a health plan's interpretation is that NQF will not require all audiences (i.e. payers, practices and providers) to report the same measures.

Measure #1901 Performance evaluation measure derived from the performance evaluation domain of the Communication Climate Assessment Toolkit

Voter Comment: [*Submitted by* America's Health Insurance Plans] While AHIP supports this measure; we recommend that measures 1901, 1905, and 1892 be combined in a single composite measure.

Voter Comment: [*Submitted by* Humana Inc.] Humana approves the measure because there is a real need, but feels that this would be better as a composite measure with l905 and 1892

Voter Comment: [*Submitted by* BCBSA] These measures can be viewed as a baseline which was established to achieve the common objective of reducing healthcare disparities. Health plans, providers and practices can opt to enhance these measures with additional measures that specifically align with their program goals.

Measure #1905 Leadership commitment measure derived from the leadership commitment domain of the Communication Climate Assessment Toolkit
Voter Comment: [*Submitted by* America's Health Insurance Plans] While AHIP supports this measure; we recommend that measures 1901, 1905, and 1892 be combined in a single composite measure.
Voter Comment: [*Submitted by* Humana Inc.] As above this measure would be better as a composite with others in this group.

Measure #1892 Individual engagement measure derived from the individual engagement domain of the Communication Climate Assessment Toolkit
Voter Comment: [*Submitted by* America's Health Insurance Plans] While AHIP supports this measure, we recommend that measures 1901, 1905, and 1892 be combined in a single composite measure.
Voter Comment: [*Submitted by* Humana Inc.] As above, this measure would better serve the goals if it were part of a composite measure that included a number from this group, such as 1901 and 1905

Measure #1894 Cross-cultural communication measure derived from the cross-cultural communication domain of the Communication Climate Assessment Toolkit
Voter Comment: [*Submitted by* America's Health Insurance Plans] AHIP is supportive of this measure; however, languages other than English and Spanish need to be included.
Voter Comment: [*Submitted by* Humana Inc.] This is an important area but should be expanded to more than English and Spanish; and should be combined with 1896

Measure #1896 Language services measure derived from the language services domain of the Communication Climate Assessment Toolkit
Voter Comment: [*Submitted by* Humana Inc.] Agree with this measure with the suggestion of creating a composite measure with 1894

Measure #1898 Health literacy measure derived from the health literacy domain of the Communication Climate Assessment Toolkit
Voter Comment: [*Submitted by* America's Health Insurance Plans] While AHIP is supportive of the health literacy measures, we believe measure #1898 should be harmonized with #1902.
Voter Comment: [*Submitted by* Humana Inc.] This measure should be sent back to the developer to harmonize with the AHRQ measure. The problem is that CAHPS has greater validation than CCAT.

Measure #1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS item Set for Addressing Health Literacy
Voter Comment: [*Submitted by* America's Health Insurance Plans] While AHIP is supportive of the health literacy measures, we believe measure #1902 should be harmonized with #1898.

Measure #1821 L2: Patients receiving language services supported by qualified language service providers
Voter Comment: [*Submitted by* America's Health Insurance Plans] While AHIP supports the evaluation of language services being provided by trained and competent interpreters, we urge the development of a composite measure for language services.

Measure #1824 L1A Screening for preferred spoken language for health care
Voter Comment: [*Submitted by* Humana Inc.] There should be harmonization with the measures of language services so that a composite measure can be generated
Voter Comment: [*Submitted by* BCBSA] In considering this measure for health plans, NQF should be aware of the requirement for linguistic appropriateness under the Interim Final Rules for Internal and External Appeals. The Rules require that each notice sent by a plan to an address in a county that meets a 10% threshold (with respect to the proportion of people who are literate only in the same non-English language) include a one-sentence statement in the relevant non-English language about the availability of language services. Plans must provide a customer assistance process (such as a telephone hotline) with oral language services in the threshold non-English language and provide written notices in that non-English language upon request. For this purpose, the Rules permit plans to direct claimants to the same customer service telephone number where representatives can first attempt to address the consumer's questions with an oral discussion, but also provide a written translation upon request in the threshold non-English language. Therefore, any measure relating to language requirements should be consistent with the requirements under the law. This is the approach taken by NCQA, which has indicated that it would accept evidence that an organization has aligned its policies and procedures with the Interim Final Rules to meet NCQA's standard to provide notices of the appeals process to members in a culturally and linguistically appropriate manner.

Measure #1919 Cultural Competency Implementation Measure
Voter Comment: [*Submitted by* Humana Inc.] This would be an appropriate measure for health plans
Voter Comment: [*Submitted by* BCBSA] In future iterations, NQF may want to consider adding at least two of the NCQA Multicultural Healthcare Distinction Program measures to ensure alignment between all nationally proposed/endorsed measures.

VOTING RESULTS

Results for each measure are provided below (The full measure summary evaluation tables are in Appendix A.)

Measure #1888 Workforce development measures derived from workforce development domain of the Communication Climate Assessment Toolkit

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	5	0	0	5	100%
Health Professional	3	1	0	4	75%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%

Purchaser	2	0	0	2	100%
QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**18**	**1**	**1**	**20**	**95%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					96%

*equation: Yes/ (Total - Abstain)

Measure #1901 Performance evaluation measure derived from the performance evaluation domain of the Communication Climate Assessment Toolkit

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	5	0	0	5	100%
Health Professional	3	1	0	4	75%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	2	0	0	2	100%
QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**18**	**1**	**1**	**20**	**95%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					96%

*equation: Yes/ (Total - Abstain)

Measure #1905 Leadership commitment measure derived from the leadership commitment domain of the Communication Climate Assessment Toolkit

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	5	0	0	5	100%
Health Professional	3	1	0	4	75%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	2	0	0	2	100%
QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**18**	**1**	**1**	**20**	**95%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					96%

*equation: Yes/ (Total - Abstain)

Measure #1892 Individual engagement measure derived from the individual engagement domain

of the Communication Climate Assessment Toolkit

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	5	0	0	5	100%
Health Professional	3	1	0	4	75%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	2	0	0	2	100%
QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**18**	**1**	**1**	**20**	**95%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					96%

*equation: Yes/ (Total - Abstain)

Measure #1894 Cross-cultural communication measure derived from the cross-cultural communication domain of the Communication Climate Assessment Toolkit

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	5	0	0	5	100%
Health Professional	3	1	0	4	75%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	2	0	0	2	100%
QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**18**	**1**	**1**	**20**	**95%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					96%

*equation: Yes/ (Total - Abstain)

Measure #1896 Language services measure derived from the language services domain of the Communication Climate Assessment Toolkit

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	5	0	0	5	100%
Health Professional	3	1	0	4	75%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	2	0	0	2	100%

QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**18**	**1**	**1**	**20**	**95%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					96%

*equation: Yes/ (Total - Abstain)

Measure #1898 Health literacy measure derived from the health literacy domain of the Communication Climate Assessment Toolkit

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	4	1	0	5	80%
Health Professional	3	1	0	4	75%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	2	0	0	2	100%
QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**17**	**2**	**1**	**20**	**89%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					94%

*equation: Yes/ (Total - Abstain)

Measure #1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS item Set for Addressing Health Literacy

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	5	0	0	5	100%
Health Professional	2	2	0	4	50%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	2	0	0	2	100%
QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**17**	**2**	**1**	**20**	**89%**
Percentage of councils approving (>50%)					86%
Average council percentage approval					93%

*equation: Yes/ (Total - Abstain)

Measure #1904 Clinicians/Groups Cultural Competence Based on the CAHPS Cultural Competence Item Set

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	5	0	0	5	100%
Health Professional	2	2	0	4	50%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	2	0	0	2	100%
QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**17**	**2**	**1**	**20**	**89%**
Percentage of councils approving (>50%)					86%
Average council percentage approval					93%

*equation: Yes/ (Total - Abstain)

Measure #1821 L2: Patients receiving language services supported by qualified language service providers

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	5	0	0	5	100%
Health Professional	4	0	0	4	100%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	2	0	0	2	100%
QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**19**	**0**	**1**	**20**	**100%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

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Measure #1824 L1A Screening for preferred spoken language for health care

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	5	0	0	5	100%
Health Professional	4	0	0	4	100%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	2	0	0	2	100%
QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**19**	**0**	**1**	**20**	**100%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

Measure #1919 Cultural Competency Implementation Measure

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	3	0	0	3	100%
Health Plan	5	0	0	5	100%
Health Professional	3	1	0	4	75%
Provider Organizations	2	0	0	2	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	2	0	0	2	100%
QMRI	2	0	1	3	100%
Supplier/Industry	0	0	0	0	
All Councils	**18**	**1**	**1**	**20**	**95%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					96%

*equation: Yes/ (Total - Abstain)

APPENDIX A: MEASURE EVALUATION SUMMARY TABLES

1888 Workforce development measure derived from the workforce developement domain of CCAT

Measure Submission Form
Description: Site score on the measure domain of "Workforce Development" of the Communication Climate Assessment Toolkit (C-CAT), 0-100.
Numerator Statement: Workforce development component of patient-centered communication: an organization should ensure that the structure and capability of its workforce meets the communication needs of the population it serves, including by employing and training a workforce that reflects and appreciates the diversity of these populations. Measure is scored on 2 items from the C-CAT patient survey and 21 items from the C-CAT staff survey. Minimum of 100 patient responses and 50 staff responses.
Denominator Statement: There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses.
Exclusions: Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.
Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Facility
Type of Measure: Patient Engagement/Experience
Data Source: Healthcare Provider Survey
Measure Steward: American Medical Association

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 17, No- 2
(1a. Impact, 1b. Performance gap, 1c. Evidence)
Rationale:
The measure showed high impact and benefit to understanding and improving communication. The Committee noted that workforce development has shown to improve disparities, but no literature was cited in measure submission to support that idea. They also noted that the citations in the submission form were dated (early 2000s), but this ultimately did not negatively affect the vote because Committee members were personally aware of more current literature to support the measure.

Scientific Acceptability of Measure Properties: Yes- 13, No- 5
(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)
Rationale:
The measure specifications presented more information about communication, although the specific domain is addressing workforce. A Committee member commented that the measure seems to be more about structure and training of staff and how that helps communication with the patient, yet only two patient questions are included in this domain, so there is no validation that staff training enhanced care. There were also reservations about whether the questions present are the best for addressing workforce development. Also noted, the use of electronic medical records is not universal, so that could be an issue with the study used to validate this measure.

Usability: High-2, Moderate-9, Low-4, Insufficient-1
(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)
Rationale:
Committee members discussed the effectiveness of the results of the survey, questioning how they are being used. The reported results would require further explanation for the public and organizations. In addition, further work is needed to assess impact on quality improvement or investment of resources. The consistency of the data may need improving to make comparisons across providers and for accountability.

Feasibility: High-1, Moderate-11, Low-5, Insufficient-1
(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)
Rationale:

1888 Workforce development measure derived from the workforce developement domain of CCAT
The accuracy of the measure relies heavily on the accuracy of self-report by staff members.
Related/Competing Measures: *(5a. Harmonization; 5b. Superior to competing measures)* **Comments:** None
Steering Committee: RECOMMEND FOR ENDORSEMENT **Does the measure meet criteria for endorsement?** Yes-11, No-6 **Rationale:** The Committee agreed with the general concept of the measure, citing the importance of workforce development and the measure was evaluated to meet criteria for reliability, validity, usability and feasibility **Recommendation:**
If Applicable, Conditions/Questions for Developer: Committee inquired about implementation of overall toolkit, as well as reporting outcomes if only a few measures from it are endorsed.
MEASURE DEVELOPER RESPONSE: In response to the Steering Committee questions of incorporating patient outcomes into the measure, the developer noted that the validation study used to support this measure found the items to be significantly related to patient-reported quality of care and patient trust. Also, regarding the concerns of implementation with 7 of the 9 CCAT measures recommended for endorsement, the developer plans to continue providing organizations with the full complement of CCAT scores for all measures, flagging those that are NQF-endorsed.

1901 Performance evaluation measure derived from the performance evaluation domain of CCAT
Measure Submission Form **Description:** Site score on domain of "performance evaluation" of the Communication Climate Assessment Toolkit (C-CAT), 0-100. **Numerator Statement:** Performance evaluation component of patient-centered communication: an organization should regularly monitor its performance with regard to each of the content areas (C-CAT domains of patient-centered communication) using structure, process and outcome measures, and make appropriate adjustments on the basis of these evaluations. **Denominator Statement:** There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses. **Exclusions:** Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact. **Adjustment/Stratification:** No risk adjustment or risk stratification **Level of Analysis:** Facility **Type of Measure:** Patient Engagement/Experience **Data Source:** Healthcare Provider Survey **Measure Steward:** American Medical Association
STEERING COMMITTEE EVALUATION
Importance to Measure and Report: Yes- 19, No- 0 *(1a. Impact, 1b. Performance gap, 1c. Evidence)* **Rationale:** Committee members discussed the concept of patient satisfaction versus quality of care, noting that patient satisfaction doesn't always equate to better outcomes, however it was also acknowledged that patient satisfaction is an important aspect of care, in particular for the area of cultural competency.
Scientific Acceptability of Measure Properties: Yes- 13, No- 6 *(2a. Reliability; 2b. Validity; 2b3. Exclusions; 2b4. Risk adjustment/stratification; 2b5. Meaningful differences; 2b6. Comparability-data sources)* **Rationale:** Measure received moderate ratings for reliability and validity testing. The Committee inquired about the pairing of patient and staff questions into a single composite rather than having separate outputs. It was noted that some of the patient items can be viewed more as outcomes and the responses may not accurately provide an organization with information that can be used to

1901 Performance evaluation measure derived from the performance evaluation domain of CCAT
improve performance. For this domain, 50% of the answers from the patient questions are supposed to be a predictor for physician performance. The developer mentioned it was a challenge to create a cohesive set of questions that would be useful for an organization that reflect the patient and staff experience and incorporate simplicity with reporting information. The goal was to give organizations a numeric score of 0-100 for each domain (measure) of the toolkit. There was some thought about differential weighting (e.g., giving staff a higher weight for some questions), but that would add to the complexity of the measure, so each question within the domain is weighted equally. In addition, the developer noted that many of the sites implementing the measure requested that certain questions remain in the survey for specific interests to that organization. The Committee also inquired about a baseline score for this measure and what that means for improvement. Measure developer considered a 5 point score change to be clinically significant and analysis was performed on changes in scoring higher than 5 points.
Usability: **High-1, Moderate-13, Low-3, Insufficient-2** *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)* **Rationale:** None
Feasibility: **High-1, Moderate-14, Low-3, Insufficient-1** *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)* **Rationale:** Committee members inquired about data collection strategy and standardization. Measure developer responded that they worked closely with hospitals during implementation to make sure they are using the most standardized way of collecting the data as is feasible. It was also noted that the measure relies heavily on self-report by staff members, and there is potential for inaccurate recall and/or biased reporting; ideally results would be collected by third parties to avoid bias.
Related/Competing Measures: *(5a. Harmonization; 5b. Superior to competing measures)* **Comments:** None
Steering Committee: RECOMMEND FOR ENDORSEMENT **Does the measure meet criteria for endorsement?** Yes-14, No-5 **Rationale:** The Steering Committee valued the importance of the measure concept and the measure was evaluated to meet the criteria for reliability, validity, usability and feasibility.
If Applicable, Conditions/Questions for Developer: None
MEASURE DEVELOPER RESPONSE: In response to the Steering Committee inquiry about measure scoring, the developer mentioned that organizations receive detailed information about their performance on the composite score, which have shown to be useful for tracking performance over time and making comparisons across organizations. The scores also comprise an aggregation of individual measure items, and each item is reported to the organization and can be stratified by both patient and staff demographics.

1905 Leadership commitment measure derived from the leadership commitment domain of CCAT
Measure Submission Form **Description:** Site score on the measure derived from the domain of "Leadership Commitment" of the Communication Climate Assessment Toolkit (C-CAT), 0-100. **Numerator Statement:** Leadership commitment component of patient-centered communication: an organization should routinely examine its commitment, capacity and efforts to meet the communication need of the population it serves, including leadership involvement; mission, goals and strategies; policies and programs; budget allocations; and workforce values. Measure is scored based on 9 items from C-CAT patient survey and 16 items from C-CAT staff survey. Minimum of 100 patient responses and 50 staff responses **Denominator Statement:** There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses. **Exclusions:** Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.

1905 Leadership commitment measure derived from the leadership commitment domain of CCAT
Adjustment/Stratification: No risk adjustment or risk stratification **Level of Analysis:** Facility **Type of Measure:** Patient Engagement/Experience **Data Source:** Healthcare Provider Survey, Patient Reported Data/Survey **Measure Steward:** American Medical Association
STEERING COMMITTEE EVALUATION
Importance to Measure and Report: Yes- 19, No- 0 *(1a. Impact, 1b. Performance gap, 1c. Evidence)* **Rationale:** The measure addresses a significant performance gap and evidence to support was generic as it relates to leadership, communication and quality. Nevertheless, the concept was viewed as important and seemed to perform well compared to the other measures derived from the domains of the toolkit.
Scientific Acceptability of Measure Properties: Yes- 14, No-5 *(2a. Reliability; 2b. Validity; 2b3. Exclusions; 2b4. Risk adjustment/stratification; 2b5. Meaningful differences; 2b6. Comparability- data sources)* **Rationale:** The measure received moderate ratings for reliability and validity testing; question items showed strong face validity. The staff questions seemed to be more unique and specific to the measure (e.g., how staff feel about leadership), however the patient questions showed more overlap with measures from other domains. The developer noted that the intent was to keep survey short and not complex and constructing questions to be universal for LEP populations. The use of the similar patient questions is used in multiple measures. In addition, patient questions for this measure were not directed toward leadership, since patient interactions with senior level staff is often limited.
Usability: High-3, Moderate-12, Low-3, Insufficient-1 *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)* **Rationale:** The results produced may be limited to moderate usefulness for accountability/public reporting and quality improvement.
Feasibility: High-3, Moderate-13, Low-2, Insufficient-1 *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)* **Rationale:** The accuracy of the measure relies heavily on the accuracy of self-report by staff members. It was noted that the data elements are not routinely generated during care delivery processes.
Related/Competing Measures: *(5a. Harmonization; 5b. Superior to competing measures)* **Comments:** None
Steering Committee: RECOMMEND FOR ENDORSEMENT **Does the measure meet criteria for endorsement?** Yes-14, No-5 **Rationale:** Leadership commitment was considered highly important for addressing disparities and cultural competency and the measure was evaluated to meet the criteria for reliability, validity, usability and feasibility.
If Applicable, Conditions/Questions for Developer: None
MEASURE DEVELOPER RESPONSE: None

1892 Individual engagement measure derived from the individual engagement domain of CCAT
Measure Submission Form **Description:** Site score on "Individuals' Engagement" domain of patient-centered communication, per the Communication Climate Assessment Toolkit (C-CAT); 0-100. **Numerator Statement:** Individual engagement: an organization should help its workforce engage all individuals, including those

1892 Individual engagement measure derived from the individual engagement domain of CCAT
from vulnerable populations, through interpersonal communication that effectively elicits health needs, beliefs, and expectations; builds trust; and conveys information that is understandable and empowering. Measure is scored on 18 items from the patient survey of the C-CAT and 9 items from the staff survey of the C-CAT. Minimum of 100 patient responses and 50 staff responses. **Denominator Statement:** There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses. **Exclusions:** Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact. **Adjustment/Stratification:** No risk adjustment or risk stratification **Level of Analysis:** Facility **Type of Measure:** Patient Engagement/Experience **Data Source:** Healthcare Provider Survey **Measure Steward:** American Medical Association
STEERING COMMITTEE EVALUATION
Importance to Measure and Report: Yes- 18, No- 1 *(1a. Impact, 1b. Performance gap, 1c. Evidence)* **Rationale:** The measure concept viewed important; affects all patients and has consequences in terms of patient experience of care. Performance demonstrates variations across scores with link to patient perceptions of quality and link to actual quality outcomes is unclear.
Scientific Acceptability of Measure Properties: Yes- 15, No-4 *(2a. Reliability; 2b. Validity; 2b3. Exclusions; 2b4. Risk adjustment/stratification; 2b5. Meaningful differences; 2b6. Comparability-data sources)* **Rationale:** The measure received moderate ratings for reliability and validity testing. It did present a more robust set of questions for patients compared to the other measures of the domains of toolkit; assesses effective communication. The staff questions demonstrated some overlap with the questions in the leadership measure. Scores on this measure are high as it relates to the correlation of items between the staff and patient questions.
Usability: High-1, Moderate-15, Low-1, Insufficient-2 *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)* **Rationale:** The measure is easily understandable and the data are supportive of the ability to identify patient satisfaction, however a limitation is an ability to show a link to actual quality or cost efficiency.
Feasibility: High-0, Moderate-17, Low-1, Insufficient-1 *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)* **Rationale:** None
Related/Competing Measures: *(5a. Harmonization; 5b. Superior to Competing Measures)* **Comments:** None
Steering Committee: RECOMMEND FOR ENDORSEMENT **Does the measure meet criteria for endorsement?** Yes-14, No-4 **Rationale:** The measure focus is important and assesses effective communication among patients and staff. The measure was evaluated to meet the criteria for reliability, validity, usability and feasibility.
If Applicable, Conditions/Questions for Developer: None
MEASURE DEVELOPER RESPONSE: None

1904 Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set
Measure Submission Form **Description:** These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey that includes the following domains: Patient-provider communication; Complementary and alternative medicine; Experiences of discrimination due to race/ethnicity, insurance, or language; Experiences leading to trust or distrust, including level of trust, caring and confidence in the truthfulness of their provide; and Linguistic competency (Access to language services). Samples for the survey are drawn from adults who have at least one provider´s visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the Core Clinician/Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifiers). Two composites can be calculated from the item set: 1) Providers are caring and inspire trust (5 items), and 2) Providers are polite and considerate (3 Items). **Numerator Statement:** We recommend that the Clinicians/Groups' Health Literacy Practices measures be calculated using the top box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses. Two composites can be calculated from the item set: 1) Providers are caring and inspire trust (5 items), and 2) Providers are polite and considerate (3 Items). **Denominator Statement:** Adults with a visit to the provider for which the survey is being fielded within the last 12 months who responded to the item. **Exclusions:** Exclusions are made when sample is drawn from provider records. Only patients 18 or older and those who have had a visit with a provider in the last 12 months are sampled. Core question 4 verifies that the respondent got care from the provider in the last 12 months. **Adjustment/Stratification:** No risk adjustment or risk stratification not applicable Stratification by race and ethnicity can be done using the following Core items: 31: Are you of Hispanic or Latino origin or descent? 32. What is your race? Mark one or more. **Level of Analysis:** Clinician : Group/Practice, Clinician : Individual **Type of Measure:** Patient Engagement/Experience **Data Source:** Patient Reported Data/Survey **Measure Steward:** Agency for Healthcare Research and Quality
STEERING COMMITTEE EVALUATION
Importance to Measure and Report: <u>Yes- 18, No-1</u> *(1a. Impact, 1b. Performance gap, 1c. Evidence)* **Rationale:** Measure concept and evidence viewed highly relevant and important
Scientific Acceptability of Measure Properties: <u>Yes- 17, No-2</u> *(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)* **Rationale:** Discussion on the range of questions varied: Committee members thought some specific cultural competency concepts were included, but others felt the questions were focused more on patient centeredness and communication. The Committee felt the items sets would need to be stratified by race, ethnicity, and language to show more of a correlation to cultural competency and disparities; concerns were expressed on labeling these questions as measuring cultural competence, when important concepts are missing. Reliability and validity received moderate ratings; it was noted that the measure was tested in diverse populations within New York and California. In response to a query about the overlap of questions between the cultural competence item set and the CAHPS health literacy measure and whether cultural beliefs were addressed during development, the measure developer stated that the overlap between the measures was deliberate—i.e., for anyone implementing just the cultural competence item set; health literacy would be addressed as well. The developer also noted there were other supplemental domains of the CAHPS survey that were not submitted for this project (i.e., language access).
Usability: <u>**High-3, Moderate-15, Low-1, Insufficient-0**</u>

(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures) **Rationale:** None
Feasibility: **High-2, Moderate-17, Low-0, Insufficient-0** *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)* **Rationale:** None
Related/Competing Measures: *(5a. Harmonization; 5b. Superior to competing measures)* **Comment:** Measure concept similar to #1919 – Cultural Competency Implementation Measure and #1894 – Cross-Cultural Communication measure of a domain of the CCAT. No harmonization issues.
Steering Committee: RECOMMEND FOR ENDORSEMENT **Does the measure meet criteria for endorsement? Yes-17, No-2** **Rationale:** Strong measure concept and well specified. Measure was evaluated to meet the criteria for reliability, validity, usability, and feasibility. **Recommendation:** Committee suggests including more specific concepts on cultural competency – inquiries on transportation, who makes decisions on healthcare, how does the patient describe the problem, religious beliefs, food, family, faith, fear, and finances.
If Applicable, Conditions/Questions for Developer: None
MEASURE DEVELOPER RESPONSE: None

1894 Cross-cultural communication measure derived from the cross-cultural communication domain of the CCAT
Measure Submission Form **Description:** Site score for "cross-cultural communication" domain of Communication Climate Assessment Toolkit (C-CAT), 0-100. **Numerator Statement:** Cross-cultural communication component of patient-centered communication (aka socio-cultural context): an organization should create an environment that is respectful to populations with diverse backgrounds; this includes helping its workforce understand sociocultural factors that affect health beliefs and the ability to interact with the health care system. Measure is scored on 3 items from the C-CAT patient survey and 16 items from the C-CAT staff survey. Minimum of 100 patient responses and 50 staff responses. **Denominator Statement:** There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses. **Exclusions:** Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact. **Adjustment/Stratification:** No risk adjustment or risk stratification **Level of Analysis:** Facility **Type of Measure:** Patient Engagement/Experience **Data Source:** Healthcare Provider Survey **Measure Steward:** American Medical Association
STEERING COMMITTEE EVALUATION
Importance to Measure and Report: Yes- 19, No- 0 *(1a. Impact, 1b. Performance gap, 1c. Evidence)* **Rationale:** Concept viewed as important for addressing disparities and cultural competency
Scientific Acceptability of Measure Properties: Yes- 14, No-5 *(2a. Reliability 2b. Validity 2b3. Exclusions; 2b4. Risk adjustment/stratification; 2b5. Meaningful differences; 2b6. Comparability-data sources)* **Rationale:** Measure received moderate ratings for reliability and validity testing
Usability: High-2, Moderate-14, Low-2, Insufficient-1

1894 Cross-cultural communication measure derived from the cross-cultural communication domain of the CCAT
(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures) **Rationale:** Not clear how patient may interpret the results or how organizations can use the results generated; does not show correlation with specific actions that healthcare systems can take.
Feasibility: High-0, Moderate-17, Low-1, Insufficient-1 *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)* **Rationale:** None
Related/Competing Measures: *(5a. Harmonization; 5b. Superior to competing measures)* **Comment:** Measure concept similar to #1919 – Cultural Competency Implementation Measure and #1904 – CAHPS Cultural Competence Item Set. No harmonization issues.
Steering Committee: RECOMMEND FOR ENDORSEMENT **Does the measure meet criteria for endorsement?** Yes-14, No-5 **Rationale:** The measure concept is important and the measure was evaluated to meet the criteria for reliability, validity, usability, and feasibility.
If Applicable, Conditions/Questions for Developer: None
MEASURE DEVELOPER RESPONSE: In response to the Committee comments on how an organization can use the results generated from this measure, the developer noted that a Resource Guide that lists potential interventions for each measure including research results to support the interventions is available upon request. The developer also noted the role of the consultants,who can provide quality improvement recommendations to an organization based on the measure results and analysis.

1896 Language services measure derived from the language services domain of CCAT
Measure Submission Form **Description:** Site score on domain of "language services" of the Communication Climate Assessment Toolkit (C-CAT), 0-100. **Numerator Statement:** Language services component of patient-centered communication: an organization should determine what language assistance is required to communicate effectively with the population it serves, make this assistance easily available and train its workforce to access and use language assistance resources. **Denominator Statement:** There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses, including at least 50 patients who prefer to speak a lan **Exclusions:** Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact. Patient respondents who report a preference for speaking English with doctors are excluded from items that pertain to translation and interpretation services, as they are unlikely to have utilized these services. **Adjustment/Stratification:** No risk adjustment or risk stratification **Level of Analysis:** Facility **Type of Measure:** Patient Engagement/Experience **Data Source:** Healthcare Provider Survey **Measure Steward:** American Medical Association
STEERING COMMITTEE EVALUATION
Importance to Measure and Report: Yes- 19, No- 0 *(1a. Impact, 1b. Performance gap, 1c. Evidence)* **Rationale:** Measure concept important and address the national priority goals of promoting effective communication.
Scientific Acceptability of Measure Properties: Yes- 15, No-4 *(2a. Reliability 2b. Validity 2b3. Exclusions; 2b4. Risk adjustment/stratification; 2b5. Meaningful differences; 2b6. Comparability-*

1896 Language services measure derived from the language services domain of CCAT
data sources) **Rationale:** The measures received moderate ratings for reliability and validity. Internal reliability shown to be in the excellent/ very good range for the patient component and internal consistency was high. Language services, however, did not show a strong correlation to patient reported trust, belief, and privacy. Committee member inquired about reverse coding on certain questions (e.g., how often have you used a child under 18 for interpretation?). Measure developer confirmed that reverse coding was used when appropriate.
Usability: **High-2, Moderate-13, Low-3, Insufficient-1** *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)* **Rationale:** None
Feasibility: **High-0, Moderate-16, Low-2, Insufficient-1** *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)* **Rationale:** None
Related/Competing Measures: *(5a. Harmonization; 5b. Superior to competing measures)* **Comment:** None
Steering Committee: RECOMMEND FOR ENDORSEMENT **Does the measure meet criteria for endorsement?** Yes-15, No-4 **Rationale:** The measure concept is important for addressing disparities and cultural competency. Measure evaluated to meet criteria for reliability, validity, usability and feasibility.
If Applicable, Conditions/Questions for Developer: None
MEASURE DEVELOPER RESPONSE: None

1898 Health literacy measure derived from the health literacy domain of CCAT
Measure Submission Form **Description:** Site score on the domain of "health literacy" of the Communication Climate Assessment Toolkit (C-CAT), 0-100. **Numerator Statement:** Health literacy component of patient-centered communication: an organization should consider the health literacy level of its current and potential populations and use this information to develop a strategy for the clear communication of medical information verbally, in writing and using other media. Measure is scored based on 15 items from the patient survey of the C-CAT and 13 items from the staff survey of the C-CAT. Minimum of 100 patients responses and 50 staff responses. **Denominator Statement:** There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses. **Exclusions:** Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact. **Adjustment/Stratification:** No risk adjustment or risk stratification **Level of Analysis:** Facility **Type of Measure:** Patient Engagement/Experience **Data Source:** Healthcare Provider Survey **Measure Steward:** American Medical Association
STEERING COMMITTEE EVALUATION
Importance to Measure and Report: Yes- 19 No-0 *(1a. Impact, 1b. Performance gap, 1c. Evidence)* **Rationale:** Measure concept important for addressing disparities and cultural competency
Scientific Acceptability of Measure Properties: Yes- 15, No-4 *(2a. Reliability 2b. Validity 2b3. Exclusions; 2b4. Risk adjustment/stratification; 2b5. Meaningful differences; 2b6. Comparability-*

1898 Health literacy measure derived from the health literacy domain of CCAT
data sources) **Rationale:** The measure received moderate ratings for reliability and validity. Reliability and validity testing for this measure had a correlation with the trust items and quality and strong face validity of the questions was noted.
Usability: High-2, Moderate-15, Low-1, Insufficient-1 *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)* **Rationale:** None
Feasibility: High-0, Moderate-16, Low-1, Insufficient-2 *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)* **Rationale:** None
Related/Competing Measures: *(5a. Harmonization; 5b. Superior to competing measures)* **Comment:** Measure concept similar to # 1902 – CAHPS Health Literacy Item set. No Harmonization issues
Steering Committee: RECOMMEND FOR ENDORSEMENT **Does the measure meet criteria for endorsement? Yes-15, No-3** **Rationale:** The measure concept is very important and highly linked to addressing cultural competency and disparities. Measure was evaluated to meet criteria for reliability, validity, usability, and feasibility.
If Applicable, Conditions/Questions for Developer: None
MEASURE DEVELOPER RESPONSE: None

1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
Measure Submission Form **Description:** These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician & Group Survey. The item set includes the following domains: Communication with Provider (Doctor), Disease Self-Management, Communication about Medicines, Communication about Test Results, and Communication about Forms. Samples for the survey are drawn from adults who have had at least one provider´s visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the core Clinician/Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifiers). Two composites can be calculated from the item set: 1) Communication to improve health literacy (5 items), and 2) Communication about medicines (3 items) **Numerator Statement:** We recommend that the Clinicians/Groups' Health Literacy Practices measures be calculated using the top box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses. Two composites can be calculated from the item set: 1) Communication to improve health literacy (5 items), and 2) Communication about medicines (3 items) **Denominator Statement:** Adults with a visit to the provider for which the survey is being fielded within the last 12 months who responded to the item. **Exclusions:** Exclusions are made when sample is drawn from provider records. Only patients 18 or older and those who have had a visit with a provider in the last 12 months are sampled. Core question 4 verifies that the respondent got care from the provider in the last 12 months. **Adjustment/Stratification:** Stratification by race, ethnicity and education can be done using the following Core Items: 30: What is the highest grade or level of school that you have completed? (6 responses) 31: Are you of Hispanic or Latino origin or descent? (2 responses) 32: What is your race? Mark one or more. (6 responses) **Level of Analysis:** Clinician : Group/Practice, Clinician : Individual

Type of Measure: Patient Engagement/Experience **Data Source:** Patient Reported Data/Survey **Measure Steward:** Agency for Healthcare Research and Quality
STEERING COMMITTEE EVALUATION
Importance to Measure and Report: Yes- 20, No-0 *(1a. Impact, 1b. Performance gap, 1c. Evidence)* **Rationale:** Strong evidence to support measure focus. Currently being utilized by Medical Expenditure Panel Survey (MEPS), a national survey fielded by AHRQ, to produce measures for Healthy People 2020 and data on cost.
Scientific Acceptability of Measure Properties: Yes- 18, No-2 *(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)* **Rationale:** The measure received moderate ratings for reliability and validity. Inquiry made about use of global physician rating scale. Developer response - It was used to show how the patients response to the items correlate to the physician performance. Concern with CAHPS only being implemented in English and Spanish, although examples were noted of the CAHPS survey being translated in other languages in California
Usability: High-6, Moderate-14, Low-0, Insufficient-0 *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)* **Rationale:** None
Feasibility: High-3, Moderate-17, Low-0, Insufficient-0 *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)* **Rationale:** Committee inquired about the national normative data for measures. Measure developer responded that since these are supplements of a larger measure (Clinician/Groups CAHPS), there isn't a large enough response rate to provide national benchmarking data. Administration of the survey for LEP patients was discussed, and it was noted that follow-up was made for anyone who didn't respond to survey.
Related/Competing Measures: *(5a. Harmonization; 5b. Superior to competing measures)* **Comment:** Measure concept similar to #1898 – Health Literacy measure for the domain of the CCAT. No Harmonization issues.
Steering Committee: RECOMMEND FOR ENDORSEMENT **Does the measure meet criteria for endorsement?** Yes-20, No-0 **Rationale:** The measure is specified well and there is strong evidence to support the concept. The measure was evaluated to meet the criteria for reliability, validity, usability and feasibility.
If Applicable, Conditions/Questions for Developer: None
MEASURE DEVELOPER COMMENTS: • Each item shown within survey is independent; questions outlined within the specifications of the measure in set do not necessarily have to all be implemented together. • Five of the items within the Health Literacy set account for 90% of the variance within the larger Clinician/Groups CAHPS Survey, which indicates the right items were selected for the measure.

1821 L2: Patients receiving language services supported by qualified language servcies providers
Measure Submission Form **Description:** This measure is used to assess the percentage of limited English-proficient (LEP) patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency.

Interpreter services are frequently provided by untrained individuals, or individuals who have not been assessed for their language proficiency, including family members, friends, and other employees. Research has demonstrated that the likely results of using untrained interpreters or friends, family, and associates are an increase in medical errors, poorer patient-provider communication, and poorer follow-up and adherence to clinical instructions. The measure provides information on the extent to which language services are provided by trained and assessed interpreters or assessed bilingual providers and bilingual workers/employees during critical times in a patient's health care experience.
Numerator Statement: The number of limited English-proficient (LEP) patients with documentation they received the initial assessment and discharge instructions supported by trained and assessed interpreters, or from bilingual providers and bilingual workers/employees assessed for language proficiency.
Note: The determination of "qualified (assessed and trained) is consistent with guidance provided by The Joint Commission, The Office of Minority Health CLAS standards; and the Office of Civil Rights.
Citations: The Joint Commission (2011), Patient-Centered Communication Standards for Hospitals, Standard HR.01.02.01; available at http:www.jointcommission.org/Advancing_Effective Communication/
65 Fed. Reg. 80865 (Dec. 22, 2000) (Department of Health and Human Services: National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care); available at http://www.omhrc.gov/clas
65 Fed. Reg. 52762 (Aug. 30, 2000) (Office for Civil Rights: Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency); available at http://www.hhs.gov/ocr/lep/preamble.html
Denominator Statement: Total number of patients that stated a preference to receive their spoken health care in a language other than English.
Exclusions: Exclusions:
•All patients stating a preference to receive spoken health care in English.
•Patients who leave without being seen.
•Patients who leave against medical advice prior to the initial assessment.
Adjustment/Stratification: No risk adjustment or risk stratification. Measure can be reported in the aggregate or stratified by preferred language. Data in measure can be used to stratify various disparities-related measures, for example: percent of LEP patients who receive all recommended diabetes care, stratified by receipt of language services.
Level of Analysis: Clinician : Group/Practice, Facility
Type of Measure: Process
Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Management Data, Paper Records
Measure Steward: Department of Health Policy, The George Washington University

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes-19, No-0
(1a. Impact, 1b. Performance gap, 1c. Evidence)
Rationale:
The Committee rated the measure high for impact and evidence. Measure concept is aligned with the Joint Commission standards on communication. This measure also aligns with the Health Information Technology for Economic and Clinical Health (HITECH) Act, which requires providers to collect data on language services.

Scientific Acceptability of Measure Properties: Yes- 17, No-2
(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)
Rationale:
The measure received moderate ratings for reliability and validity. Committee members discussed the measure specifications, expressing concern about defining a "qualified" language service provider, noting the measure did not indicate specifics for setting a bar for defining this. The measure developer responded that during testing, organizations were encouraged to define what a qualified interpreter was for their institution. The differences and challenges with training and certifications for language services providers was discussed (e.g., differences between trained bilingual staff, part-time interpreters versus full-time, and the range of services for someone who is qualified). Several suggestions for defining qualified language services providers was provided, such as minimum number of hours for training, requiring specific testing for language proficiency, etc. Recent developments in the field of certification and training for interpreters was mentioned, specifically the certification program developed by the Certification Commission for Healthcare Interpreters. Overall, the Committee agreed highly with the measure

concept and specifications.

Usability: **High-2, Moderate-16, Low-1, Insufficient-0**
(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)
Rationale:
Measure is currently in use within the Aligning Forces for Quality, a quality improvement program funded through the Robert Wood Johnson Foundation.

Feasibility: **High-0, Moderate-17, Low-1, Insufficient-1**
(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)
Rationale:
How to operationalize the measure was discussed, specifically the data collection strategy during the initial assessment, which is defined as a patient encounter. It was noted that the purpose of a patient encounter can vary and the first person a patient encounters may not always be a healthcare professional. In response to a Committee inquiry, the measure developer mentioned that the goal of the measure was to identify the important times and encounters for which interpreters should be present. The initial assessment is defined as the patient's first encounter with a provider who is qualified to assess and treat the patient and discharge is the last encounter. It was also noted that a specifications manual is available to help define the terms and encounters for determining where information should be recorded.

Related/Competing Measures:
(5a. Harmonization; 5b. Superior to Competing Measure)
Comment: None

Steering Committee: **RECOMMEND FOR ENDORSEMENT**
Does the measure meet criteria for endorsement? **Yes-17, No-2**
Rationale: This measure is evidence-based and consistent with standards established by the Joint Commission and is consistent with the recommendations of the Institute of Medicine.
Recommendation: The Committee recommends providing some clarification or citation for defining a qualified language services provider.

If Applicable, Conditions/Questions for Developer:
To clarify the Committee's concerns about "qualified language providers, the measure developer agreed to include a footnote in the measure specifications to provide clarification on qualified language service providers.

MEASURE DEVELOPER RESPONSE:
The following footnote was added to the measure specifications

- Note: The determination of "qualified (assessed and trained) is consistent with guidance provided by The Joint Commission, The Office of Minority Health CLAS standards; and the Office of Civil Rights.
- Citations: The Joint Commission (2011), Patient-Centered Communication Standards for Hospitals, Standard HR.01.02.01; available at http://www.jointcommission.org /Advancing_Effective Communication/ 65 Fed. Reg. 80865 (Dec. 22, 2000) (Department of Health and Human Services: National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care); available at http://www.omhrc.gov/clas 65 Fed. Reg. 52762 (Aug. 30, 2000) (Office for Civil Rights: Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency); available at http://www.hhs.gov/ocr/lep/preamble.html

The developer also noted that the measure represents an important focus for hospitals because many were not recording this information at the patient level. During implementation, organizations were required to document whether people providing interpreter services met the standards set by their own organization.

1824 L1A: Screening for preferred spoken language for health care

Measure Submission Form
Description: This measure is used to assess the percent of patient visits and admissions where preferred spoken language for health care is screened and recorded.

Hospitals cannot provide adequate and appropriate language services to their patients if they do not create mechanisms to screen for limited English-proficient patients and record patients´ preferred spoken language for health care. Standard practices of collecting preferred spoken language for health care would assist hospitals in planning for demand. Access to and availability of patient language preference is critical for providers in planning care. This measure provides information on the extent to which patients are asked about the language they prefer to receive care in and the extent to which this information is recorded.
Numerator Statement: The number of hospital admissions, visits to the emergency department, and outpatient visits where preferred spoken language for health care is screened and recorded
Denominator Statement: The total number of hospital admissions, visits to the emergency department, and outpatient visits.
Exclusions: There are no exclusions. All admissions, visits to the emergency department, and outpatient visits, including:
•Scheduled and unscheduled visits
•Elective, urgent and emergent admissions
•Short stay and observation patients
•Transfers from other facilities
Adjustment/Stratification: No risk adjustment or risk stratification. Non-English Speaking Populations can be identified from screening to determine if needed language services were delivered. Clinical performance measures can be stratified by language to examine whether disparities exist among varying language groups.
Level of Analysis: Clinician : Group/Practice, Facility
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records
Measure Steward: Department of Health Policy, The George Washington University

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes-20, No-0
(1a. Impact, 1b. Performance gap, 1c. Evidence)
Rationale:
Strong evidence of a performance gap in terms of screening for preferred language. Measure is Important for assessing disparities at the organizational level and addresses specific recommendation from the Institute of Medicine report, Race, Ethnicity and Language Data: Standardization for Healthcare Quality. Screening for a need of language services is an important first step to getting the services for patients.

Scientific Acceptability of Measure Properties: Yes- 20, No-0
(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)
Rationale:
Measure received high/moderate ratings for reliability and validity. Committee noted a strong face validity; screening variation across settings was low. Measure is simple and straight forward – does exactly what it's intended to do.

Usability: High-10, Moderate-9, Low-1, Insufficient-0
(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)
Rationale: None

Feasibility: High-11, Moderate-9, Low-0, Insufficient-0
(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)
Rationale:
High feasibility – very minimal burden on organizations to implement. Operationalizing the measure was discussed, specifically addressing how often a patient is screened for preferred spoken language. The measure developer mentioned that organizations decide on how often they will ask a patient for this information during encounters. Language has to be documented for credit on the measure.

Related/Competing Measures:
(5a. Harmonization; 5b. Superior to competing measure)
Comments: None

Steering Committee: RECOMMEND FOR ENDORSEMENT

Does the measure meet criteria for endorsement? Yes-20, No-0 **Rationale:** The measure has a good evidence-base and minimal burden for implementation. Overall, this measure is an important first step to assess and improve language services for LEP population. **Recommendation:**
If Applicable, Conditions/Questions for Developer: The Committee recommended that a future iteration of the measure include additional stakeholders (e.g., health plans)

1919: Cultural Competency Implementation Measure

Measure Submission Form

Description: 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.

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.

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.

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.

Level of Analysis: Facility, Health Plan, Integrated Delivery System

Type of Measure: Patient Engagement/Experience

Data Source: Healthcare Provider Survey

Measure Steward: RAND

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 14, No-3, Insufficient-3

(1a. Impact, 1b. Performance gap, 1c. Evidence)

Rationale:

Most of the Committee members agreed the measure concept and focus was important. One inquiry was made about the variability of the questions and whether this was clinically relevant. The measure developer mentioned linking this directly to outcomes was not the focus of this test, but that generally accepted cultural competency is an important component of quality. It was summarized that there appeared to be general agreement in the Committee that the measure was important, but perhaps at this time indirectly linked to clinical relevance.

Scientific Acceptability of Measure Properties:

Reliability: High-1, Moderate-13, Low-3, Insufficient-3; **Validity:** High-0, Moderate-9, Low-7, Insufficient-4

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

Committee members discussed the low response rate (18%) during the testing. It was noted that half of the responses were from Federally Qualified Health Centers, which represents a certain demographic and organizations that are likely to be predisposed to the concept of cultural awareness and patient diversity. The measure developer agreed the testing sample was small, but did not think the low response rate was unusual. The developer noted that the sample size was sufficient to do the necessary analytics; along with the pre-field cognitive testing. The importance of the inter-rater reliability was mentioned and the possible effect on the response rate. In particular, it was noted that the size of the organization can affect the rate of the inter-rater reliability; larger organizations may experience more issues with this versus smaller organizations who may be more

1919: Cultural Competency Implementation Measure
consistent with responses. The measure developer noted that they had determined whether the responding organizations understood the items for the survey. The developer also noted that the respondent was required to have the CEO or comparable individual attest to the results. The Committee inquired about the specifics of who the responders were within the organizations completing the survey (e.g., support staff, medical staff, and senior leadership). The measure developer mentioned that most people who responded to the survey were working within a quality improvement capacity or responsible for culturally competency or completing hospital surveys within their perspective organizations. It was noted that it was not possible for one person to complete the survey alone in some organizations—i.e., people were required to speak with individuals in other departments. The survey was targeted and sent to the CEO/COO of an organization, and it was their responsibility to distribute the survey to the correct person for completing it.
Usability: <u>High-3, Moderate-14, Low-2, Insufficient-1</u> *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)* **Rationale:** Committee members expressed difficulty with assessing usability since the measure has not been widely distributed outside the testing sample. Two Committee members felt the survey's intended breadth of many different types of organizations made usability low. Another Committee member felt that, in fact, this was the strength of this particular survey measure, considering most of the other endorsed measure are limited to only point-of-care organizations. The measure developer briefly discussed usability, noting that the measure was recently developed and to date has not been made publicly available outside the testing sample.
Feasibility: <u>High-3, Moderate-10, Low-3, Insufficient-3</u> *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)* **Rationale:** Committee members discussed the variability in the response rate and mentioned the difficulty to assess who in fact completed the survey. In response to a question about how long it took to respond to the survey, the developer reported that the responses ranged from a few minutes to 3 hours, with the average about 1 hour. In response to a Committee member's question about non-responders, the measure developer mentioned that follow-up was made with those who did not respond to the survey initially. The most common reasons were conflict with an existing survey period for another instrument; timeframe for response given the test period was more compressed than usual; and not participating in surveys not required.
Related/Competing Measures: (5a. Harmonization; 5b. Superior to competing measures) **Comment:** Measure concept similar to #1894 – Cross-Cultural Communication measure of a domain of the CCAT and # 1904 CAHPS – Cultural Competence Item Set. No harmonization issues
Steering Committee: <u>RECOMMEND FOR ENDORSEMENT</u> **Does the measure meet criteria for endorsement?** <u>Yes-12, No-8</u> **Rationale:** Overall the Committee agreed this is a high impact area; organizational cultural competency is an important step to developing the culture that will support quality of care and improved health outcomes for patients. The measure specifications were clear yet adaptable based on the organization(s)' characteristics. In addition, the measures of similar concepts do not include large healthcare organizations, which is a strength of this measure. **Recommendation:** Committee members did encourage the developers to conduct more extensive field testing.
If Applicable, Conditions/Questions for Developer: None
MEASURE DEVELOPER RESPONSE: None