NATIONAL QUALITY FORUM

TO: NQF Members and Public

FR: NQF Staff

RE: Pre-Voting review for *Healthcare Disparities and Cultural Competency Consensus Standards*

DA: June 6, 2012

The Healthcare Disparities and Cultural Competency Consensus Standards Project seeks to identify and endorse measures addressing healthcare disparities and cultural competency for public reporting/accountability and quality improvement applicable to all settings of care. This project builds on NQF's 2006 project focused on disparities-sensitive measures for ambulatory care and establishing criteria to evaluate disparities-sensitive measures, as well as NQF's 2009 Consensus Report on a Framework and Preferred Practices for Cultural Competency.

A 25-member Steering Committee representing a range of stakeholder perspectives was appointed to evaluate sixteen new measures against NQF's measure evaluation criteria. The Steering Committee recommends 12 measures for endorsement.

The draft document, *National Voluntary Consensus Standards for Healthcare Disparities and Cultural Competency*, is posted on the NQF website, along with the measure submission forms for the Steering Committee's discussions. On May 9, 2012, the 30-day comment period concluded for the 12 measures recommended in the draft report.

COMMENTS AND REVISED VOTING REPORT

NQF received 70 comments from a variety of stakeholders, including 10 Member organizations and 5 organizations that are not NQF members. The commenting organizations (Table 1) represent a variety of stakeholders:

Consumers – 2
Professionals – 3
Providers – 1
QMRI – 1
Non-NQF member organizations – 5
Purchasers – 0
Health Plans – 2
Public & Community Health – 2
Supplier and Industry – 0
Individuals – 0

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 measure submission forms. Revisions to the draft report and the accompanying measure specifications are represented as red-lined changes.

COMMENTS AND THEIR DISPOSITION

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.

Revisions to the draft report and the accompanying measure specifications are identified as Red-lined changes. (NOTE: Typographical errors and grammatical changes have not been red-lined to assist in reading.)

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 has recommended both measures for endorsement for several reasons, in particular 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 yrs.

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 emphasizes 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 question), 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."

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 C-CAT 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 C-CAT receive these stratified data. Finally, for sites that use the C-CAT 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."

VOTING

Information for electronic voting has been sent to NQF Member organization primary contacts. Accompanying comments must be submitted via the online voting tool.

Please note that voting concludes on June 20, 2012, at 6:00 pm ET. There are no exceptions.

Thank you.

NATIONAL QUALITY FORUM

HEALTHCARE DISPARITIES AND CULTURAL COMPETENCY CONSENSUS STANDARDS

DRAFT TECHNICAL REPORT FOR VOTING

JUNE 6, 2012

NATIONAL QUALITY FORUM

TABLE OF CONTENTS

NATIONAL QUALITY FORUM

HEALTHCARE DISPARITIES AND CULTURAL COMPETENCY CONSENSUS STANDARDS

Draft Technical Report

INTRODUCTION

One essential step to improving the overall quality of healthcare performance is to eliminate disparities in care experienced by socially disadvantaged population groups. Many people consider healthcare disparities to be the result of factors such as late stage presentation of disease, specific health conditions, socioeconomic status, and access to care. However, the Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* demonstrated that racial and ethnic minorities often receive lower-quality care than their white counterparts, even after controlling for factors such as insurance, socioeconomic status, comorbidities, and stage of presentation. Among other factors found to contribute to healthcare disparities are inadequate resources, poor patient-provider communication, a lack of culturally competent care, and inadequate linguistic access. To reduce healthcare disparities, healthcare systems likely will need to improve in all these areas. Accurate and meaningful metrics to measure healthcare disparities and culturally competent care are needed to create a long-term agenda for improving healthcare quality for populations adversely affected by disparities and ensuring equitable allocation of healthcare resources. By analyzing the effectiveness of existing quality measures and identifying gaps, the National Quality Forum (NQF) aims to establish valid and reliable measurement of healthcare disparities and cultural competency across settings and populations.

The Healthcare Disparities and Cultural Competency Consensus Standards project sought to enhance NQF's 2006 work addressing disparities and cultural competency, which included establishing criteria to evaluate disparities-sensitive measures and endorsing 35 disparity-sensitive measures for the ambulatory care setting under the project National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities. Also, in 2009, NQF completed an extensive project endorsing a definition, framework, and set of 45 preferred practices for measuring and reporting cultural competency under the project A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency. This 2011 project had two phases: (1) development of a commissioned paper focused on measurement implications 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.

MEASURING HEALTHCARE DISPARITIES

The commissioned paper on Healthcare Disparities Measurement, developed by The Disparities Solution Center at Massachusetts General Hospital, provided background context and recommendations to NQF regarding the selection and evaluation of 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.

Recommendations for methodological approaches and concepts for disparities measurement

The Committee discussed a wide range of methodological issues that arise in measuring and reporting disparities data, and ultimately mirrored the vast majority of work outlined in the commissioned paper in the following areas:

- data collection;
- reference point;
- absolute and relative disparities;
- favorable and adverse measures;
- paired comparisons and summary statistics;
- normative judgments about disparity measures;
- risk adjustment and stratification;
- interaction effects;
- sample size considerations; and
- socioeconomic and other demographic variables

Data Collection: The preferred method for collecting race/ethnicity and language data is self-identified. Solidifying and supporting an infrastructure for race, ethnicity, and language proficiency data collection from patients/members within all healthcare settings should be a high priority. There is clear guidance from IOM/NQF/HRET that should be followed for self-reporting (the gold standard). Where not feasible in the short term, indirect estimation can serve as a complementary technique to self-identified data.

Reference Point: The reference point serves as the specific value against which a disparity is measured. The reference point always should be the historically advantaged group, not the largest or best performing in an area/on a measure.

Absolute versus Relative Disparities and Favorable versus Adverse Measures: The absolute and relative changes in disparities can reveal different conclusions about whether gaps are actually closing and often can lead to different interpretations when making these comparisons. Both absolute and relative statistics should be calculated, and if they lead to conflicting conclusions, then both statistics should be reported, allowing users to reach their own conclusion. In addition, trends should be calculated and specific rates provided along with a narrative for explanation.

Paired Comparisons versus Summary Statistics: Pairwise comparisons using the historically advantaged group as the reference point should be assessed to determine if a positive finding from the summary statistic reflects superior care received by the disadvantaged group—and if so, then the context of that result and relevant policy goals should be explicitly considered.

Normative Judgments about Disparity Measures: Normative judgments and inherent biases should be minimized. When used in reported measures, they should be mentioned and referenced appropriately. In addition, further evaluation of the measure and reference point for which the normative judgment is based should be explained.

Risk Adjustment and Stratification: Stratification by race/ethnicity and preferred language ~~primary language~~ should be performed when there are sufficient data to do so. While recognizing that performance may be dependent on community factors beyond a provider's control, existing NQF policy is that risk models should not include race/ethnicity adjusters, which may mask disparities in quality of care.

Interaction Effects: When clear differences in quality exist by racial/ethnic sub-strata, further stratification of results serves to highlight areas of the greatest potential for intervention. Additional variables to consider for stratification include income, age, highest level of education, acculturation, and urban/rural effects and language. Some or all of these may elucidate areas for intervention. An interaction effect should be acknowledged, but reported only if it is large enough to make a difference on the disparity gap.

Sample Size Consideration: The Committee recognized that sample size considerations have a huge impact on the ability to report and accurately report performance data, generally, and especially disparities-related information. Toward that end, several options to overcome sample size issues while providing meaningful disparities data are:

1. Race/ethnicity categories such as those recommended by the IOM report – *Race, Ethnicity, and Language Data: Standardization for Healthcare Quality Improvement* can be "rolled up" into broader categories containing more than one group. For example, using use the OMB categories is a common approach, or even minority and majority.
2. Use a summary statistic which considers all of the racial/ethnic groups simultaneously.
3. Use composite quality measures. Composite measures provide a global comparison of the quality of care by combining across indicators to produce a "composite" or "aggregate" score. Composite scores can be generated using much smaller sample sizes than those required for single indicators.
4. Over-sample minority patients, including race, ethnicity, and language as well as other sub-groups.
5. Combine data from two or more years.

Consideration of Socioeconomic and Other Demographic Variables: Performance reports stratified by race/ethnicity should not be risk adjusted by socioeconomic status or other contributory factors, and instead should be further stratified if the data permit. While stratification is a better option for identifying differences in the underlying diverse population, there should be some sensitivity to over adjusting for disparities within a population.

Identifying Disparities Measures and Indicators

Along with providing recommendations for measurement concepts that should be developed for disparities, the Steering Committee identified a protocol for identifying measures as disparities-sensitive. NQF had previously established criteria for evaluating disparities-sensitive measures as part of *National Voluntary Consensus Standards for Ambulatory Care – Measuring Healthcare Disparities*; using these criteria as a foundation, the Steering Committee provided further recommendations to refine and operationalize a protocol with specific indicators around disparities sensitivity (i.e., prevalence, quality gap, and impact, linkage to clinical guidelines, social-determinants, and communication sensitive services).

Certain selection criteria have demonstrated to be more subjective than others, such as actionability versus impact. Of note, an alternate approach to selecting disparities-sensitive measures was discussed. Specifically, an approach of “opt in” versus “opt out” (i.e., assuming all measures as disparities-sensitive and then use the selection criteria to remove measures as appropriate). NQF is currently utilizing the recommendations of the Committee to review the existing portfolio of NQF-endorsed measures and tagging those applicable as disparities-sensitive (Appendix D).

In addition to using the systematic protocol to evaluate and “tag” disparities-sensitive measures in NQF’s existing portfolio, the Committee recommended that NQF consider process and outcome measures separately to ensure both types are represented at this time. Similarly, the disparities-sensitive subset should be examined to ensure representation of system-based vs. provider-based measures. Additionally, cross-cutting measures should be identified. Finally, the Committee noted that all disparities-sensitive measures should be stratified by race/ ethnicity and language and that institutions should consider prioritizing measures for implementation and uptake.

NQF’s Approach for Measuring Disparities Prospectively

Going forward, the Committee emphasized the importance of considering whether a measure should be viewed as important for assessing disparities during the general NQF evaluation and/or maintenance processes. The Committee recommended changes to the measure submission form, as follows: – (1) advising measure developers more specifically about including disparities data within the submission form; (2) aggregating the currently dispersed disparities sections within each evaluation criterion to a new, separate section toward the beginning of the form; and (3) considering disparities as a threshold criterion for NQF endorsement.

MEASURE EVALUATION

The Steering Committee evaluated 16 measures against NQF's evaluation criteria. The Steering Committee included expertise in cultural competency, disparities measurement, and research, medicine, and public and community health with a focus on disparities. To facilitate the evaluation of the measures, Committee members were divided into four workgroups, which focused on evaluation of the sub-criteria and criteria with input on overall suitability for endorsement from the broader Steering Committee on February 23-24, 2012 and March 16. The Committee's discussion and workgroup ratings of the criteria are summarized in the evaluation tables beginning on page 14.

Table 1. 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	

Overarching Issues

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.

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 organizations capacity of cultural and linguistic competency.

Alignment with national strategies around cultural competency and disparities

Measures should acknowledge and align with existing voluntary accreditation standards or national recommendations related to disparities and cultural competency. Several standards and publications 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 is 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 mentioned above 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 (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 any organized public reporting or pay-based incentives.
- Using 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 high-minority providers, and direct supplemental resources to those providers for improving disparities and including 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 of incentivizing the patient toward better behavior modifications

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

Indirect data collection

Although acknowledging that indirect collection of race/ethnicity data offer 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 concurred with by the Committee to accelerate the advancement of healthcare equity and literacy:

- Support efforts that focus on translating scientific evidence into everyday 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 health care 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 Steering 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 measures 1898 – *Health Literacy measure of the C-CAT* and 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 coverage by the questions in the specifications for each. Cultural Competency measures 1919 – *Cultural Competency Implementation Measure*, 1894 – *Cross-cultural measure of the C-CAT* and 1904 – *Clinicians/Groups' Cultural Competence Based on the CAHPS Item Set for Addressing Cultural Competence*. One difference and benefit for the RAND Cultural Competency Implementation Measure is the applicability for multiple care settings. It was mentioned that there is an absence of measures addressing cultural competency for other healthcare organizations, such as health plans. (CCAT is hospital-based.) The burden of implementing all three related measures by a single organization also was noted. It was clarified that an organization considering these measures for implementation can choose which measure to utilize depending on the measure set's applicability to the organizations 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. A comparison of the measure specifications can be found in Appendix C.

RECOMMENDATIONS FOR FUTURE MEASURE DEVELOPMENT

The Steering Committee discussed gaps related to disparities measures and identified several recommendations. The recommendations included three groups: 1) existing measure sets that were not submitted for consideration; 2) gaps in applicable settings for measures, and 3) concepts for which there are no existing measures.

Existing measure sets

An important gap noted immediately was a measure on data collection. The concept of data collection is well researched and aligned with various policy statements on quality improvement and the Committee noted that measures currently exist on data collection, however, a measure was not recommended by the Steering Committee[1]. Data collection should address whether healthcare organizations are collecting race/ethnicity/language data and the process for doing so.

The existing measure set of multicultural standards from the National Committee for Quality Assurance was mentioned, several elements embedded in these standards address gaps including community engagement and a process to develop programs for improving cultural and linguistic services based on healthcare disparities analysis.

Gaps in applicable settings

Most of the measures considered were tested only in hospitals; however there are multiple care settings and various organizations for which the measures should be applicable (e.g., health and dental plans, nursing homes, physician offices and integrate medical groups, home health agencies, dialysis centers, disease management companies, pharmacy benefit management companies and community health centers).

Future Disparities-related ~~C~~concepts for future measure development

The Committee discussed several important measure concepts related to disparities and cultural competency, specifically beyond the concept of race, ethnicity, and language that should be priorities for measure development.

- Leadership and accountability
- Addressing other populations with known disparities, e.g., gender, persons with disabilities, lesbian, gay, bisexual, and transgender (LGBT) population and correctional populations
- Health-related quality of life
- Inclusion of socioeconomic status variables within measure concepts, such as education level or income – particularly as proxies for health literacy/beliefs
- Tracking the flow of information specific to disparities and culture within healthcare through accountable care organizations.
- Identifying the number of bilingual/bicultural providers and tracking the number of qualified/certified medical interpreters and translators.
- Measures using comparative analyses with a reference population (e.g., percent adherence of a given measure with the targeted population as a numerator and the reference or majority population as the denominator with serial assessments to demonstrate improvement to unity).
- Measurement of the effectiveness of services provided to the patient
- Measures related to effective engagement of diverse communities

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[1] NQF has endorsed the *HRET Disparities Toolkit: A toolkit for collecting race, ethnicity and primary language information from patients* under the project – A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report ~~Framework and Preferred Practices~~.

The Steering Committee also discussed measurement concepts in general for disparities, noting a difference between measures that address culture and equity versus traditional clinical measures stratified by race, ethnicity, and language. It noted there should be a clear distinction for disparities-specific measures focused on race, culture, and language; stratified reporting of a measure by race, ethnicity, and language does not mean it was specified or designed to address disparities, and organizations should use both types of measures. The Committee suggested that a framework/typology was needed for disparities measures (e.g., potential risk-factors for disparities, health literacy versus realized disparities, stratifying measures for certain disparities indicators).

The Steering Committee also discussed the need to effectively use health IT systems and data systems to track and eliminate disparities. Measures that can assess the capability of health IT systems to capture disparities-related data are needed. In particular, measures should address Meaningful Use Core Objective #7 related to the recording of demographic data, including preferred language, gender, race, ethnicity, and date of birth[2].

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[2] Centers for Medicare and Medicaid Services. *Eligible Professional Meaningful Use Core Measures – Record Demographics*. EHR Incentive Programs. 2010.

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MEASURE EVALUATION TABLES

MEASURES RECOMMENDED

MEASURES NOT RECOMMENDED

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MEASURE EVALUATION SUMMARIES

The evaluation summary tables include brief measure specifications and descriptive measure information, evaluation ratings, rationales, follow-up with measure developers, and final recommendation. The full measure specifications for the recommended measures are included in Appendix A. The full measure submissions for all measures are available on the Healthcare Disparities project page. Hyperlinks are also provided at the beginning of each measure.

MEASURES RECOMMENDED

The Steering Committee reviewed and evaluated nine domains of the Communication Climate Assessment Toolkit (CCAT), recommending seven for endorsement. The components of the toolkit were tested and scored separately as individual measures; a single composite score across all domains is not calculated for the toolkit.

Committee members inquired about several components of the measures including scoring, correlation of patient and staff questions for each domain, and testing. A summary of the measure developer responses follows:

- Seven of the nine measures are positively correlated with language and trust. The domains addressing data collection and language services are not correlated, however, these measures can stand alone.
- Correlation between results for patient and staff questions is not strong; patient questions were reduced after first round of testing and scoring for each item is equally weighted.
- Overlap and redundancy between the measure domains was reviewed and minimized to the extent possible.
- Sample sizes used in the study provided strong numbers for stratification by race/ethnicity, however scores were not published[3].
- ~~For implementation of the CCAT, ~~There were questions related to implementation of the CCAT. The measures themselves are freely available for download. -C~~c~~onsultants may be utilized to ~~is provided to ~~assist with data collection and analysis of scores for each measure, which are reported separately for patient and staff questions, as well as recommendations to ~~an ~~organizations based on the results from the measure score and analysis.

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[3] Wynia et al. Validation of an Organizational Communication Climate Assessment Toolkit. *American Journal of Medical Quality*; 2010.

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:

The accuracy of the measure relies heavily on the accuracy of self-report by staff members.

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

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 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

1901 Performance evaluation measure derived from the performance evaluation domain of CCAT
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: ~~None~~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.

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

1905 Leadership commitment measure derived from the leadership commitment domain of CCAT
Steering Committee: <ins>RECOMMEND FOR ENDORSEMENT</ins> Does the measure meet criteria for endorsement? <ins>Yes-14, No-5</ins> 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 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

1892 Individual engagement measure derived from the individual engagement domain of CCAT
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

(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: ~~None~~ 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. ~~mentioned an important~~ The developer

1894 Cross-cultural communication measure derived from the cross-cultural communication domain of the CCAT
also noted the role of the ~~trained~~ consultants, ~~-~~who ~~which includes~~ can provide ~~ing~~ 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-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-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.

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: Yes- 18, No-1 *(1a. Impact, 1b. Performance gap, 1c. Evidence)* **Rationale:** Measure concept and evidence viewed highly relevant and important
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:** 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: High-3, Moderate-15, 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-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

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)
MEASURE DEVELOPER RESPONSE: None

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 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

1919: Cultural Competency Implementation Measure
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

MEASURES NOT RECOMMENDED

1881 Data collection domain of Communication Climate Assessment Toolkit

Measure Submission Form

Description: Site score on the domain of "Data Collection" of the Communication Climate Assessment Toolkit (C-CAT), 0-100.

Numerator Statement: Data collection component of patient-centered communication: an organization should used standardized qualitative and quantitative collection methods and uniform coding systems to gather valid, reliable information for understanding the demographics and communication needs of the population it serves. Measure is scored on 3 items from the C-CAT patient survey and 9 items from the C-CAT staff survey.

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.

Patients who report a preference for speaking English with physicians are excluded from items that ask about translation and interpretation services (p46 & p49).

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 Assocation

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes-17, No-2

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

Rationale:

Measure concept important for addressing disparities and evidence based one expert opinion reports/experiential data.The goal of the measure was discussed: Was the goal to also assess potential impact or only focused on data collection? The developer noted that measure is focused on data collection and is not necessarily designed to show the downstream effects of such collection. The measure focus was to encourage organizations to collect the data per se.

Scientific Acceptability of Measure Properties: 2a. Reliability: High-1, Moderate-14, Low-4, Insufficient-0; 2b. Validity: High-0, Moderate-7, Low-12, Insufficient-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:

Reliability testing was judged reasonable, but validity testing was judged low. Specifically, no correlation between the data collection sub-scales. Specific questions were not correlated against chart reviews of quality. Many of the questions are not the best or most current with respect to concepts of accurate, valid data collection. The spread/score for the test population is good, but there is no evidence or further information on what these scores mean or how the scores are correlated across other quality domains. All four subscales of the measure have the same evidence, but no strong evidence to validate them and there was no validated proof and citations for the specific measure of data collection; broader literature presented

Steering Committee: NOT RECOMMENDED FOR ENDORSEMENT

Rationale:

Strong face validity, but did not use right questions for this measure as it relates to data collection to show improved quality improvement. Correlation issue on quality improvement. Measure could not be validated in a positive manner, raises concerns with accountability if endorsed.

If Applicable, Conditions/Questions for Developer:

Suggestion was made to remove questions, including only 3-4 patient questions with updated information based on the Institute of Medicine report and other similar reports. Developer may want to consider hierarchy of ordering questions to help with feasibility. Measure developer mentioned that the average length of time to complete the survey was 10 minutes for patients and 15-20 minutes for staff.

MEASURE DEVELOPER COMMENTS: None

1828 L3: Patient wait time to receive interpreter servcies

Measure Submission Form

Description: This measure is used to assess the percent of encounters where the wait time for an interpreter is 15 minutes or less. Patients and providers report resistance or reluctance to using interpreter services due to long wait times or delays in obtaining an interpreter upon request. As interpreter services continue to evolve, many hospitals across the country have adopted standards for wait times for interpreter encounters. This measure provides information on the extent to which interpreter services are able to respond to requests for service within a reasonable amount of time, defined here as within 15 minutes.

Numerator Statement: The number of interpreter encounters in which the wait time is 15 minutes or less for the interpreter to arrive

Denominator Statement: The total number of interpreter encounters, stratified by language.

Exclusions: Exclusions

- Encounters with bilingual providers and/or other bilingual workers/employees
- Encounters with outside vendor telephone interpreters
- Encounters with outside vendor video interpreters

Adjustment/Stratification: No risk adjustment or risk stratification. Aggregate measure provides information about timeliness of interpreter services and is a disparities-related measure since long waits for interpreters cause delays only for patients who speak languages other than English. Hospitals can stratify measure by language, location or type of service, mode of interpreting, scheduled versus unscheduled appointments

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-9, No-10

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

Rationale:

Quality of evidence to support measure is low; no clear evidence to show that reducing wait times for interpreters will improve quality care and reduce disparities. Face validity of the concept is good, and measure addresses one of the IOM's six aims of improvement (timeliness), however there was high variability across testing sites and the quality of care doesn't show improvement based on reduced wait time for interpreters. Lack of evidence to support the specific time interval component (15 minutes) specified for the measure. It was noted, however, that the U.S. Office of Civil Rights opposes LEP patients waiting longer or unnecessarily when English speaking patients are treated sooner, but if all patients are waiting 30 minutes, then this measure may drive a different type of inequity.

Steering Committee: NOT RECOMMENDED FOR ENDORSEMENT

Rationale:

Measure did not pass importance, a threshold criterion. Feasibility may be difficult: Who is measuring when the interpreter is called and when they show up? Usability of results and how patients will use this information wasn't clear. The results would need to be stratified by certain language. Timeliness component of measure may encourage people to rush when using interpreters or use the wrong or inappropriate interpreters.

If Applicable, Conditions/Questions for Developer: None

MEASURE DEVELOPER RESPONSE:

Developer doesn't disagree with the Committee's assessment on the evidence. The developer noted, however, that during testing one of the biggest complaints was the wait time for interpreters, which could affect whether or how the care was provided.

1831 L5: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers

Measure Submission Form

Description: The percent of work time interpreters spend providing interpretation in clinical encounters with patients and providers.

Numerator Statement: The total number of minutes interpreters spent providing interpretation during clinical encounters during the calendar month, stratified by language.

Denominator Statement: The total number of minutes worked by interpreters during the calendar month, stratified by language.

Exclusions: Exclusions:

- Vacation, sick time, orientation and education leave.
- Agency and contract interpreters.
- Persons whose primary responsibility is administrative (e.g., interpreter manager, supervisor, director, interpreter department dispatcher, secretary, and scheduler).
- Interpreters assigned to non interpreter duties (e.g., shift supervisor, special projects).
- Outside vendor telephone interpreters and outside vendor video interpreters.
- Bilingual providers and other bilingual hospital workers/employees.

Adjustment/Stratification: No risk adjustment or risk stratification. Measure can be stratified by language of interpretation. If interpreter provides services in one non-English language, all time spent interpreting in clinical situations can assumed to be for that language and recorded as such. Some interpreters provide services for more than one non-English language. Language of encounter should be recorded for each encounter.

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-2, No-19

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

Rationale:

Timeliness component of measure not shown to improve outcomes. Committee mentioned variability in the types of interpreter services. Committee also identified a potential unintended consequence: Staff interpreters may be replaced with contractors to meet measure requirements.

Steering Committee: NOT RECOMMENDED FOR ENDORSEMENT

Rationale:

Measure did not pass importance, a must pass criterion

If Applicable, Conditions/Questions for Developer:

MEASURE DEVELOPER COMMENTS:

Developer mentioned that from a quality improvement perspective, this measure was important. It served as an indicator for hospitals to track whether they are using their resources properly. The developer acknowledged that it doesn't have a direct care patient link, but noted the goal was to track utilization and productivity with the previous measure of 'patients receiving a language service.'

1886 Community engagement domain of Communication Climate Assessment Toolkit

Measure Submission Form

Description: Site score on the domain of "Community Engagement" of the Communication Climate Assessment Toolkit (C-CAT), 0-100.

Numerator Statement: Community Engagement component of patient-centered communication: an organization should make demonstrable, proactive efforts to understand the community it serves, including establishing relationships with community groups and developing opportunities for community members to participate in shaping organizational policies. Measure is scored based on 3 items from C-CAT patient survey and 3 items from C-CAT staff survey. Minimum n 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:

Committee agreed the concept of community engagement was important for addressing disparities and cultural competency.

Scientific Acceptability of Measure Properties: 2a. Reliability: High-0, Moderate-15, Low-4, Insufficient-0;
2b. Validity: High-0, Moderate-8, Low-10, Insufficient-1

(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 questioned whether this measure accurately accounts for community engagement, noting differences between having staff to represent the community and an organization engaging with a community. Measure validity was judged to be low—it doesn't accurately measure *how* the community is engaged based on questions. Committee concluded that items should be focused on other concepts, such as patient resources within the community. Implementation of measure unclear: How does an organization define its community and stakeholders? In addition, organizations would need to know who completed survey questions to accurately target improvements.

Steering Committee: NOT RECOMMENDED FOR ENDORSEMENT

Rationale:

- Measure was judged low for validity, a must pass criterion.
- Committee did not agree measure questions reflected the right concepts to assess community engagement.

If Applicable, Conditions/Questions for Developer: None

MEASURE DEVELOPER RESPONSE: None

APPENDIX A – MEASURE SPECIFICATIONS

	1821 L2: Patients receiving language services supported by qualified language servcies providers
Steward	Department of Health Policy, The George Washington University
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.
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Management Data, Paper Records Hospitals utlilized and modified existing clinical documentation resources to collect data and to produce measure results through all 3 collaborative programs (Speaking Together; AF4Q Language Quality Improvement Collaborative; and the AF4Q Hospital Quality Network´s Improving Language Services). URL http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3870218A-5056-9D20-3D6DA9069C41BB77.pdf URL http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3870218A-5056-9D20-3D6DA9069C41BB77.pdf
Level	Clinician : Group/Practice, Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Hospital/Acute Care Facility
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
Numerator Details	Time Window: The time window is an encounter or point in time. All cases in the denominator are equally eligible to appear in the numerator Inclusions: The number of limited English-proficient (LEP) patients with documentation that they received both initial assessment and discharge instructions supported by: . *Assessed and trained interpreters; or, . Bilingual providers or bilingual workers/employee *assessed for language proficiency. Exclusions: • Patients receiving initial assessment and/or discharge instructions supported by interpreters who have not met the organization's *training and assessment requirements. • Patients receiving initial assessment and/or discharge instructions from a bilingual provider or bilingual worker/employee who has not met the organization's *training and assessment requirements. • Patients receiving initial assessment and/or discharge instructions supported by family or friends. • There is no documentation indicating provision of qualified language services provided at initial assessment and/or discharge instructions. Data Elements: -Preferred spoken language for health care -Initial assessment -Discharge instructions Definitions: * 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. Definitions: Preferred spoken language for health care: the preferred language that is stated by the patient for speaking to health care providers. This includes ASL. Initial assessment: the first evaluation from a medical doctor, nurse practitioner, or physician assistant (excludes triage, medical assistant, nurse aid). Discharge instructions: discussion of the instructions with the nurse at the end of a hospital stay or ED visit. The instructions from the medical doctor, nurse, nurse practitioner or physician assistant at the end of an outpatient visit. Interpreter: an individual whose primary job responsibility is to render a message spoken or signed in one language into a second language without adding, omitting, or distorting meaning or editorializing. Professional interpreters abide by a code of professional ethics and practice what is called, "transparent interpreting". [NCIHC, CHIA, and TCE] Bilingual provider: a person with proficiency in more than one language, enabling the person to provide services directly to limited-English proficient patients in their non-English language. [NCIHC] Bilingual worker/employee: an employee who is a proficient speaker of two languages, usually English and a language other than English, who is often called upon to interpret for limited-English proficient patients, but who is usually not trained as a professional interpreter. [NCIHC]
Denominator Statement	Total number of patients that stated a preference to receive their spoken health care in a language other than English.
Denominator Details	Time Window: Time window is a single point in time. All cases in the denominator are equally eligible to appear in the numerator Inclusions: •All patients indicating or stating a preference to receive spoken health care in a language other than English. Exclusions: •All patients indicating or stating a preference to receive spoken health care in English. Data Elements: Preferred spoken language for health care Definition: Preferred spoken language for health care: the preferred language that is stated by the patient for speaking to health care providers. This includes ASL.
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.
Exclusion Details	•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.
Risk Adjustment	None
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.
Type Score	Rate/proportion better quality = higher score
Algorithm	Data calcuated as aggregate numerator and demoninator, monthly, stratified by language, declined or unavailable. URL http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3870218A-5056-9D20-3D6DA9069C41BB77.pdf
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	1824 L1A: Screening for preferred spoken language for health care
Steward	Department of Health Policy, The George Washington University
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.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records Data on language preferences is generally collected at the point of admission, whether as an inpatient, emergency department patient, or ambulatory patient. Some health care organizations use registration systems that are linked with other sources of information; others use electronic health records that include registration/administrative data and clinical data. URL http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3870218A-5056-9D20-3D6DA9069C41BB77.pdf URL http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3870218A-5056-9D20-3D6DA9069C41BB77.pdf
Level	Clinician : Group/Practice, Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Hospital/Acute Care Facility
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
Numerator Details	Time Window: Time window is a single point in time. All cases in the denominator are equally eligible to appear in the numerator. Data Elements: Preferred spoken language for health care Admissions Visits Definitions: Admissions: a patient health care encounter involving an inpatient stay, whether this is a direct admit to the hospital (scheduled or unscheduled) or occurs through the emergency department. Preferred spoken language for health care: the preferred language that is stated by the patient for speaking to health care providers. This includes ASL. Visit: patient health care encounter with a provider in the hospital emergency department, ambulatory unit or clinic.
Denominator Statement	The total number of hospital admissions, visits to the emergency department, and outpatient visits.
Denominator Details	Time Window: Time window is a single point in time. All cases in the denominator are equally eligible to appear in the numerator Data Elements: Admissions Visits Definitions: Admission: a patient health care encounter involving an inpatient stay, whether this is a direct admit to the hospital (scheduled or unscheduled) or occurs through the emergency department. Visit: patient health care encounter with a provider in the hospital emergency department, ambulatory unit or clinic.
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
Exclusion Details	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
Risk Adjustment	None
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.
Type Score	Rate/proportion better quality = higher score
Algorithm	Data Reported As: Aggregate numerator and denominator, monthly, stratified by language, including English, declined, or unavailable. Numerator: •Count the number of patient admissions and/or visits for which preferred spoken language for health care is recorded. •Apply inclusions and exclusions. •Stratify by language, including English, declined, or unavailable. Denominator: •Count the total number of patient admissions and/or visits. •Stratify by language, including English, declined, or unavailable. Notes for Abstraction: •If patient refused to answer and declined is recorded, credit for screening for preferred spoken language for health care may be taken. •If electronic systems pre-populate the language preference field, credit for screening for preferred spoken language for health care may be taken for this admission or visit. •If a space on a document or field in an electronic system for recording language preference for health care is not populated, credit for screening for preferred spoken language for health care may not be taken. •If the patient’s preferred written language for health care information is recorded and the preferred spoken language for health care is not recorded, credit for screening spoken language may not be taken. Notes: •All patients should be asked to self-identify their preferred spoken language for health care. The goal is for the patient, not the provider or registration/scheduling staff, to self-identify preferred spoken language for health care. •Suggested screening question: “What language do you prefer to speak with your doctor or nurse?” •American Sign Language (ASL) should be included as a preferred spoken language for health care for this measure. •Organizational policy should specify whose preferred spoken language for health care should be documented for pediatric patients and for incapacitated adults. •For example, Organizational policy may require that the preferred spoken language for health care for a parent, family member or caregiver is recorded in the event of a minor child or incapacitated adult. •Some organizations pre-populate fields so that certain data are present at subsequent admissions and/or visits. •For example, address, phone number, and insurance are often pre-populated. Some organizations also pre-populate language information fields. •Please note: Organizational policy should specify whether preferred spoken language for health care should be asked at every admission/visit or verified periodically. •For newborns: if it is for the birth, the newborn is excluded from the denominator. If the newborn is admitted to the hospital from day 1 forward (and the mother is not admitted to the hospital), the newborn is included in the denominator. •For Emergency Department visits, hospitals should report all visits (i.e., all who come for care) and not just those who are admitted to the hospital. Declined: a person who is unwilling to choose/provide a language category or cannot identify him/herself with one of the listed languages. This category is an indication that the person did NOT want to respond to the question and should not be asked again during the same visit or during a subsequent visit. [HRET]

	Unavailable: a patient who is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Can be called "Unknown," "Unable to complete," or "Other." This category is an indication that the person could not respond to the question and can be asked again during the same visit or during a subsequent visit. [HRET] HRET: Hasnain-Wynia, R., Pierce, D. HRET disparities toolkit: A toolkit for collecting race, ethnicity, and primary language information from patients. The Health Research and Education Trust. February 2005. URL http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3870218A-5056-9D20-3D6DA9069C41BB77.pdf
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	1902 Clinicians/Groups’ Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
Steward	Agency for Healthcare Research and Quality
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)
Type	Patient Engagement/Experience
Data Source	Patient Reported Data/Survey CAHPS Item Set for Addressing Health Literacy Attachment CAHPS Item Set to Address Health Literacy 1-31-12.docx
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office
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)
Numerator Details	Time Window: Last 12 months. Top Box Method: Calculate the number of responses in the most positive response category for each item. Below each item is listed with the most positive response for the item in parentheses. Note that for HL1, HL2, HL3, HL5, HL6, and HL17 the most positive response is "Never.” Specific instructions for how reverse coding can be done in SAS can be found in "Instructions for Analyzing CAHPS Data" (available at: https://www.cahps.ahrq.gov/Surveys-Guidance/Dental/~/media/Files/SurveyDocuments/Dental/Prep_Analyze/2015_instructions_for_analyzing_data.pdf) in the section called “Data Set Specification.” HL1 In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English? (Never) HL2 In the last 12 months, how often did this provider use medical words you did not understand? (Never) HL3 In the last 12 months, how often did this provider talk too fast when talking with you? (Always) HL4 In the last 12 months, how often did this provider use pictures, drawings, models, or videos to explain things to you? (Always) HL5 In the last 12 months, how often did this provider ignore what you told him or her? (Never) HL6 In the last 12 months, how often did this provider interrupt you when you were talking? (Never) HL7 In the last 12 months, how often did this provider show interest in your questions and concerns? (Always) HL8 In the last 12 months, how often did this provider answer all your questions to your satisfaction? (Always) HL9 In the last 12 months, how often did this provider give you all the information you wanted about your health? (Always) HL10 In the last 12 months, how often did this provider encourage you to talk about all your health questions or concerns? (Always) HL11 In the last 12 months, did you see this provider for a specific illness or for any health condition? [screener for HL 12-17] (NA) HL12 In the last 12 months, did this provider give you instructions about what to do to take care of this illness or health condition (Yes) HL13 In the last 12 months, how often were these instructions easy to understand? (Always) HL14 In the last 12 months, how often did this provider ask you to describe how you were going to follow these instructions? (Always)

	1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
	HL15 Sometimes providers give instructions that are hard to follow. In the last 12 months, how often did this provider ask you whether you would have any problems doing what you need to do to take care of this illness or health condition? (Always) HL16 In the last 12 months, how often did this provider explain what to do if this illness or health condition got worse or came back? (Always) HL17 In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Never) HL18 In the last 12 months, did this provider prescribe any new medicines or change how much medicine you should take? [screener for HL19-25] (NA) HL19 In the last 12 months, did this provider give instructions about how to take your medicines? (Yes) HL20 In the last 12 months, how often were these instructions about how to take you medicines easy to understand? (Always) HL21 In the last 12 months, did this provider explain the possible side effects of your medicines? (Yes) HL22 In the last 12 months, how often were these explanations was easy to understand? (Always) HL23 In the last 12 months, other than a prescription, did this provider give you written information or write down information about how to take your medicines? (Yes) HL24 In the last 12 months, how often was the written information you were given easy to understand? (Always) HL25 In the last 12 months, how often did this provider suggest ways to help you remember to take your medicines? (Always) Core 21 In the last 12 months, did this provider order a blood test, x-ray, or other test for you? [screener for Core 22] (NA) Core 22 In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?(NA) [screener for HL26] HL26 In the last 12 months, how often were the results of your blood test, x-ray, or other test easy to understand? (Always) HL27 In the last 12 months, did you sign any forms at this provider's office [screener for HL28] (NA) HL28 In the last 12 months, how often did someone explain the purpose of a form before you signed it? (Always) HL29 In the last 12 months, did you fill out any forms at this provider's office? [screener for HL30-31] (NA) HL30 In the last 12 months, how often were you offered help to fill out a form at this provider's office? (Always) HL31 In the last 12 months, how often were the forms from this provider's office easy to fill out? (Always)
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.
Denominator Details	Time Window: Last 12 months. The denominator is the total number of respondents who selected a response option to a particular item. Respondents may have not answered an item because of a screener that skipped them over that item, or because they chose to skip that question.
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.
Exclusion Details	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.
Risk Adjustment	No risk adjustment or risk stratification not applicable.
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)
Type Score	Non-weighted score/composite/scale better quality = higher score
Algorithm	Composites can be calculated for an individual provider (e.g., a doctor), or for a practice or clinic. The Communication to Improve Health Literacy Composite consists of 5 items: HL9. In the last 12 months, how often did this provider give you all the information you wanted about your health? (Response:

	1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
	Never/Sometimes/Usually/Always) HL10. In the last 12 months, how often did this provider encourage you to talk about all your health problems or concerns? (Response: N/S/U/A) HL14. In the last 12 months, how often did this doctor ask you to describe how you were going to follow these instructions? (Response: N/S/U/A) HL20. In the last 12 months, how often were these instructions about how to take you medicines easy to understand? (Response: N/S/U/A) HL26. In the last 12 months, how often were the results of your blood test, x-ray or other test easy to understand? (Response: N/S/U/A) The Communication about Medicines Composite consists of 3 items: HL22. In the last 12 months, how often were these explanations [of possible side effects of your medicines] easy to understand? (Response: N/S/U/A) HL24. In the last 12 months, how often was the written information you were given easy to understand? (Response: N/S/U/A) HL25. In the last 12 months, how often did this provider suggest ways to help you remember to take your medicines? (Response: N/S/U/A) To calculate the Communication to Improve Health Literacy Composite: STEP1: Calculate the proportion of respondents in each response category for each item in the composite (i.e., the number of respondents who gave the response divided by the total number of respondents who answered that item). Start by calculating for HL9: • The proportion of respondents who answered "never" • The proportion of respondents who answered "sometimes" • The proportion of respondents who answered "usually" • The proportion of respondent who answered "always" Follow this step for HL10, HL14, HL20, and HL26. STEP 2: Calculate the average proportion responding to each category across the questions in the composite. For example, to calculate the composite for those who answered "always," calculate: (Proportion of respondents who answered "always" to HL9 + Proportion of respondents who answered "always" to HL10 + Proportion of respondents who answered "always" to HL14 + Proportion of respondents who answered "always" to HL20 + Proportion of respondents who answered "always" to HL26)/5 Repeat STEP 2 for the proportion of respondents who answered "usually," the proportion of respondents who answered "sometimes," and the proportion of respondents who answered "never." The Communication about Medicines Composite is calculated in the same way, except that – because there are only 3 items in the composite, the denominator in the calculation of the average proportion responding to each category should be divided by 3. Additional detail on the algorithm to calculate these composites is available from the CAHPS® Clinician & Group Surveys Instructions for Patient Experience Measures. Instructions for analyzing composite measures in SAS are available in the CAHPS Clinician & Group Surveys and Instructions, Instructions for Analyzing Data. Both are available at: https://www.cahps.ahrq.gov/Surveys-Guidance/CG/Get-CG-Surveys-and-Instructions.aspx. URL https://www.cahps.ahrq.gov/Surveys-Guidance/CG/Get-Surveys-and-Instructions.aspx
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	1904 Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set
Steward	Agency for Healthcare Research and Quality
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).
Type	Patient Engagement/Experience
Data Source	Patient Reported Data/Survey CAHPS Cultural Competence Item Set Attachment CAHPS Cultural Competence Item Set 1-31-12 revised.docx
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office
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).
Numerator Details	Time Window: Last 12 months Top Box Method: Calculate the number of responses in the most positive response category for each item. Below each item is listed with the most positive response indicated in parentheses. Note that for CU1, CU2, CU3, CU4, CU5, CU14, and CU15, the most positive response is "Never." Specific instructions for how reverse coding can be done in SAS can be found in "Instructions for Analyzing CAHPS Data" (available at: https://www.cahps.ahrq.gov/Surveys-Guidance/Dental/~/media/Files/SurveyDocuments/Dental/Prep_Analyze/2015_instructions_for_analyzing_data.pdf) in the section called "Data Set Specification." CU1 In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English? (Never) CU2 In the last 12 months, how often did this provider use medical words you did not understand? (Never) CU3 In the last 12 months, how often did this provider talk too fast when talking with you? (Never) CU4 In the last 12 months, how often did this provider ignore what you told him or her? (Never) CU5 In the last 12 months, how often did this provider interrupt you when you were talking? (Never) CU6 In the last 12 months, how often did this provider show interest in your questions and concerns? (Always) CU7 In the last 12 months, how often did this provider answer all your questions to your satisfaction? (Always) CU8 In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Never) CU11 In the last 12 months, has this provider ever asked you if you have used an acupuncturist or an herbalist to help with an illness or to stay healthy? (Yes) CU13 In the last 12 months, has this provider ever asked you if you used natural herbs? (Yes) CU14 In the last 12 months, how often have you been treated unfairly at this provider´s office because of your race or ethnicity? (Never) CU15 In the last 12 months, how often have you been treated unfairly at this provider´s office because of the type of health insurance you have or because you don´t have health insurance? (Never) CU16 In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else? Yes, definitely CU17 In the last 12 months, did you feel you could trust this provider with your medical care? (Yes, definitely) CU18 In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news? (Yes, definitely) CU19 In the last 12 months, did you feel this provider cared as much as you do about your health? (Yes, definitely) CU20 In the last 12 months, did you feel this provider really cared about you as a person? (Yes, definitely) CU21 Using any number from 0 to 10, where 0 means that you do not trust this provider at all and 10 means that you trust this provider completely, what number would you use to rate how much you trust this provider? (9-10) CU23 An interpreter is someone who helps you talk with others who do not speak your language. Interpreters can include staff from the doctor's office or telephone interpreters. In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge? (Yes) CU25 In the last 12 months, when you needed an interpreter to help you speak with doctors or other health providers, how often did you get one? (Always)

	CU28 In the last 12 months, how often did this interpreter treat you with courtesy and respect? (Always) CU29 Using any number from 0 to 10, where 0 is the worst interpreter possible and 10 is the best interpreter possible, what number would you use to rate this interpreter? (9-10) CU31 Did any of your appointments start late because you had to wait for an interpreter? (No) CU33 In the last 12 months, did you use friends or family members as interpreters because that was what you preferred? (Yes)
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.
Denominator Details	Time Window: Last 12 months The denominator is the total number of respondents who selected a response option to a particular item. Respondents may have not answered an item because of a screener that skipped them over that item, or because they chose to skip that question.
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.
Exclusion Details	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.
Risk Adjustment	No risk adjustment or risk stratification not applicable
Stratification	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.
Type Score	Non-weighted score/composite/scale better quality = higher score
Algorithm	Composites can be calculated for an individual provider (e.g., a doctor), or for a practice or clinic. The Providers Are Caring and Inspire Trust Composite consists of 5 items in the composite: CU16. In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else? (Response: Never/Sometimes/Usually/Always) CU17. In the last 12 months, did you feel you could trust this provider with your medical care? (Response: N/S/U/A) CU18. In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news? (Response: N/S/U/A) CU19. In the last 12 months, did you feel this provider cared as much as you do about your health? (Response: N/S/U/A) CU20. In the last 12 months, did you feel this provider really cared about you as a person? (Response: N/S/U/A) The Providers Are Polite and Considerate Composite consists of 3 items: CU3. In the last 12 months, how often did this provider talk too fast when talking with you? (Response: N/S/U/A) CU8. In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Response: N/S/U/A) CU5. In the last 12 months, how often did this provider interrupt you when you were talking? (Response: N/S/U/A) To calculate the Providers Are Caring and Inspire Trust Composite: STEP1: Calculate the proportion of respondents in each response category for each item in the composite (i.e., the number of respondents who gave the response divided by the total number of respondents who answered that item). Start by calculating for CU16: • The proportion of respondents who answered “never” • The proportion of respondents who answered “sometimes” • The proportion of respondents who answered “usually” • The proportion of respondent who answered “always” Follow this step for CU17, CU18, CU19, and CU20. STEP 2: Calculate the average proportion responding to each category across the questions in the composite. For example, to calculate the composite for those who answered “always,” calculate: (Proportion of respondents who answered “always” to CU16 + Proportion of respondents who answered “always” to CU17 + Proportion of respondents who answered “always” to CU18 + Proportion of respondents who answered “always” to CU19 + Proportion of respondents who answered “always” to CU20)/5

	Repeat STEP 2 for the proportion of respondents who answered “usually,” the proportion of respondents who answered “sometimes,” and the proportion of respondents who answered “never.” The Communication about Medicines Composite is calculated in the same way, except that – because there are only 3 items in the composite, the denominator in the calculation of the average proportion responding to each category should be divided by 3. Additional detail on the algorithm to calculate these composites is available from the CAHPS® Clinician & Group Surveys Instructions for Patient Experience Measures. Instructions for analyzing composite measures in SAS are available in the CAHPS Clinician & Group Surveys and Instructions, Instructions for Analyzing Data. Both are available at: https://www.cahps.ahrq.gov/Surveys-Guidance/CG/Get-CG-Surveys-and-Instructions.aspx. URL https://www.cahps.ahrq.gov/Surveys-Guidance/CG/Get-Surveys-and-Instructions.aspx

	1888 Workforce development measure derived from the workforce development domain of CCAT
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	0-100 measure of workforce development related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit
Type	Patient Engagement/Experience
Data Source	Healthcare Provider Survey Communication Climate Assessment Toolkit (C-CAT) survey instruments (staff and patient). Available at: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page URL http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? Attachment Workforce development data library.xls
Level	Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
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.
Numerator Details	Time Window: Open data collection period -- ideally all C-CAT data are collected in a discreet data collection period ranging from 1-4 weeks. However, in order to achieve sufficient data sites with smaller patient populations, or those looking to collect data from a specific sub-group, may require a longer data-collection period. Patient items: p16 (pp16): Did doctors explain things in a way you could understand? p33 (pp33): Do hospital (clinic) staff come from your community? Staff items: s4: Senior leaders have worked to recruit employees that reflect the patient community. s5: Senior leaders have rewarded staff and departments that work to improve communication. s6: My direct supervisors have intervened if staff were not respectful towards patients. s7: My direct supervisors have monitored whether I communicate effectively with patients. s8: My direct supervisors have provided useful feedback on how to improve my communication skills. s9: My direct supervisors have asked for my suggestions on how to improve communication within the hospital (clinic). s10: My direct supervisors have used my feedback to improve communication within the hospital (clinic). s16: Hospital (clinic) staff members have communicated well with patients over the phone. s17: Hospital (clinic) staff members have communicated with each other respectfully. s18: Hospital (clinic) staff members have communicated with each other effectively to ensure high quality care. s19: Hospital (clinic) staff members have needed more time to communicate well with patients. s52: Have you ever received specific and adequate training on communication policies at the hospital (clinic)? s53: Have you ever received specific and adequate training on the impact of miscommunication on patient safety? s54: Have you ever received specific and adequate training on the importance of communicating with patients in plain language instead of using technical terms? s55: Have you ever received specific and adequate training on ways to check whether patients understand instructions (such as the teach-back or the “show-me” methods)? s56: Have you ever received specific and adequate training on interacting with patients from diverse cultural and spiritual backgrounds? s57: Have you ever received specific and adequate training on how to ask patients about their health care values and beliefs? s58: Have you ever received specific and adequate training on how to ask patients about their racial/ethnic background in a culturally appropriate way? s60: Have you ever received specific and adequate training on finding out when patients need an interpreter? s61: Have you ever received specific and adequate training on how to work with interpreters effectively? s62: Training from the hospital (clinic) has helped me communicate better with patients.

	See field 2a1.20 for measure score calculation logic.
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.
Denominator Details	Time Window: A brief, discreet data-collection period is preferred. A data-collection period of between 1-4 weeks is usually sufficient to collect needed data. Staff respondents should include all staff categories, including both clinical and non-clinical staff as well as those in roles such as building/environmental services, food services, etc. A minimum of 50 staff responses in a variety of staff categories is required to calculate the measure score. Staff surveys are made available in English and Spanish by default, with additional language available upon request. Patient respondents include all patients, with a pediatric version made available for families of minor patients. During field testing, patient surveys were available in 5 languages: English, Spanish, Chinese, Polish and Vietnamese. Currently, English and Spanish language surveys are made available by default with additional languages available upon request (languages determined by organization using the C-CAT). During field testing of the instruments, surveys were available on paper or online and during phase 1 patient surveys were also available via automated voice response systems. After very few patients replied using the voice automated system, the system was retired from use.
Exclusions	Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.
Exclusion Details	Based on response to the first item on the staff survey ("Does your job involve direct contact with patients? yes/no"), staff respondents who do not have direct contact with patients are excluded from items that relate to direct contact with patients.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Non-weighted score/composite/scale better quality = higher score
Algorithm	The measure score is an average of the patient and staff components. Calculation of patient component of measure score: each response of "never" counts as 0; each response of "sometimes" counts as 0.5; each response of "always" counts as 1.0; responses of "not sure" are excluded. A composite score for each item is calculated by summing the total response scores and dividing by the number of valid responses ("not sure" excluded); this operation is repeated for each item; an average of all patient items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the patient component of "workforce development." For the staff component: Each response of “no training” counts as 0; each response of “inadequate training” counts as 0.5; each response of “adequate training” counts as 1.0. Each response of "strongly disagree" counts as 0; each response of "disagree" counts as 0.33; each response of "agree" counts as 0.67; each response of "strongly agree" counts as 1.0; responses of "n/a" or "not sure" are excluded. A composite score for each item is calculated by summing the total response score and dividing by the number of valid responses ("n/a" and "not sure" excluded); this operation is repeated for each item; an average of all staff items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the staff component of the domain of "workforce development." The average of the staff and patient components is obtained, resulting in the measure score for the domain of workforce development regarding patient-centered communication.
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	1892 Individual engagement measure derived from the individual engagement domain of CCAT
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	0-100 measure of individual engagement related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit
Type	Patient Engagement/Experience
Data Source	Healthcare Provider Survey Communication Climate Assessment Toolkit (C-CAT) survey instruments (staff and patient). Available at: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? URL http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? Attachment Individual engagement data library.xls
Level	Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
Numerator Statement	Individual engagement: an organization should help its workforce engage all individuals, including those 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.
Numerator Details	Time Window: Open data collection period -- ideally all C-CAT data are collected in a discreet data collection period ranging from 1-4 weeks. However, in order to achieve sufficient data sites with smaller patient populations, or those looking to collect data from a specific sub-group, may require a longer data-collection period. The measure result is obtained by calculating a 0-100 score for both the patient and staff component of the measure. Item language is adjusted based on whether site is a hospital or clinic. Patient survey items: p5 (pp5): Could you understand the people at the front desk? p6 (pp6): Was it easy to ask questions at the hospital (clinic)? p7 (pp7): Were the hospital (clinic)’s forms easy for you to fill out? p8 (pp8): Did hospital (clinic) staff offer to help you fill out the forms? p9 (pp9): Did you understand the hospital (clinic)’s informed consent forms? p10 (pp10): Was information in the waiting areas helpful? p11 (pp11): Did you take educational materials home from the hospital (clinic)? p12 (pp12): Did the educational materials meet your needs? p13 (pp13): Were the educational materials easy to understand? p14 (pp14): Did doctors listen to you? p15 (pp15): Did doctors respect what you had to say? p18 (pp18): Did doctors involve you in decisions about your health care? p21 (pp21): Did doctors ask if you had any questions? p22 (pp22): Did you have enough time to talk with your doctor? p23 (pp23): Did you know your main health problem? p24 (pp24): Did you understand your doctor’s instructions? p25 (pp25): Did you know how to take your medicine? p26 (pp26): Was it easy to reach someone on the phone if you had a question? Staff survey items: s1: Senior leaders have taken steps to create a more welcoming environment for patients. s2: Senior leaders have taken steps to promote a more patient-centered environment. s6: My direct supervisors have intervened if staff were not respectful towards patients. s11: My direct supervisors have encouraged me to get patients more involved in their health care decisions. s16: Hospital (clinic) staff members have communicated well with

	patients over the phone. s44: Overall, how would you rate the hospital (clinic)'s informed consent forms? s48: Overall, how would you rate the hospital (clinic)'s efforts to help patients access community resources (e.g., assistance with medications, nutrition, insurance, legal aid, etc.)? s54: Have you ever received specific and adequate training on the importance of communicating with patients in plain language instead of using technical terms? s57: Have you ever received specific and adequate training on how to ask patients about their health care values and beliefs? See field 2a1.20 for measure score calculation logic.
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.
Denominator Details	Time Window: A brief, discreet data-collection period is preferred. A data-collection period of between 1-4 weeks is usually sufficient to collect needed data. Staff respondents should include all staff categories, including both clinical and non-clinical staff as well as those in roles such as building/environmental services, food services, etc. A minimum of 50 staff responses in a variety of staff categories is required to calculate the measure score. Staff surveys are made available in English and Spanish by default, with additional language available upon request. Patient respondents include all patients, with a pediatric version made available for families of minor patients. During field testing, patient surveys were available in 5 languages: English, Spanish, Chinese, Polish and Vietnamese. Currently, English and Spanish language surveys are made available by default with additional languages available upon request (languages determined by organization using the C-CAT). During field testing of the instruments, surveys were available on paper or online and during phase 1 patient surveys were also available via automated voice response systems. After very few patients replied using the voice automated system, the system was retired from use.
Exclusions	Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.
Exclusion Details	Based on response to the first item on the staff survey ("Does your job involve direct contact with patients? yes/no"), staff respondents who do not have direct contact with patients are excluded from items that relate to direct contact with patients.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Non-weighted score/composite/scale better quality = higher score
Algorithm	The measure score is an average of the patient and staff components. Calculation of patient component of measure score: Each response of "never" counts as 0; each response of "sometimes" counts as 0.5; each response of "always" counts as 1.0; responses of "not sure" are excluded. A composite score for each item is calculated by summing the total response scores and dividing by the number of valid responses ("not sure" excluded); this operation is repeated for each item; an average of all patient items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the patient component of "individual engagement." For the staff component: Each response of "very poor" counts as 0; each response of "poor" counts as 0.25; each response of "fair" counts as 0.5; each response of "good" counts as 0.75; each response of "very good" counts as 1.0. Each response of "no training" counts as 0; each response of "inadequate training" counts as 0.5; each response of "adequate training" counts as 1.0. Each response of "strongly disagree" counts as 0; each response of "disagree" counts as 0.33; each response of "agree" counts as 0.67; each response of "strongly agree" counts as 1.0; responses of "n/a" or "not sure" are excluded. A composite score for each item is calculated by summing the total response score and dividing by the number of valid responses ("n/a" and "not sure" excluded); this operation is repeated for each item; an average of all staff items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the staff component of the domain of "individual engagement." The average of the staff and patient components is obtained, resulting in the measure score for the domain of individual engagement regarding patient-centered community.
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	1894 Cross-cultural communication measure derived from the cross-cultural communication domain of the CCAT
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	0-100 measure of cross-cultural communication related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit
Type	Patient Engagement/Experience
Data Source	Healthcare Provider Survey Communication Climate Assessment Toolkit (C-CAT) survey instruments (staff and patient). Available at: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page URL http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? Attachment cross-cultural communication data library.xls
Level	Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
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.
Numerator Details	Time Window: Open data collection period -- ideally all C-CAT data are collected in a discreet data collection period ranging from 1-4 weeks. However, in order to achieve sufficient data sites with smaller patient populations, or those looking to collect data from a specific sub-group, may require a longer data-collection period. The measure result is obtained by calculating a 0-100 score for both the patient and staff component of the measure. Item language is adjusted based on whether site is a hospital or clinic. Patient survey items: p16 (pp16): Did doctors explain things in a way you could understand? p19 (pp19): Did doctors at the hospital (clinic) try to understand your culture? p20 (pp20): Could you talk to your doctors about home remedies? Staff survey items: s1: Senior leaders have taken steps to create a more welcoming environment for patients. s2: Senior leaders have taken steps to promote a more patient-centered environment. s6: My direct supervisors have intervened if staff were not respectful towards patients. s12: My direct supervisors have encouraged me to talk with patients about cultural and spiritual beliefs that might influence their health care. s13: Hospital (clinic) staff members have shown that they care about communicating effectively with diverse populations. s16: Hospital (clinic) staff members have communicated well with patients over the phone. s17: Hospital (clinic) staff members have communicated with each other respectfully. s19: Hospital (clinic) staff members have needed more time to communicate well with patients. s41: Overall, how would you rate the cultural appropriateness of the hospital (clinic)'s patient education materials? s44: Overall, how would you rate the hospital (clinic)'s informed consent forms? s48: Overall, how would you rate the hospital (clinic)'s efforts to help patients access community resources (e.g., assistance with medications, nutrition, insurance, legal aid, etc.)? s52: Have you ever received specific and adequate training on communication policies at the hospital (clinic)? s53: Have you ever received specific and adequate training on the impact of miscommunication on patient safety? s56: Have you ever received specific and adequate training on interacting with patients from diverse cultural and spiritual backgrounds? s57: Have you ever received specific and adequate training on how to ask patients about their health care values and beliefs?

	s58: Have you ever received specific and adequate training on how to ask patients about their racial/ethnic background in a culturally appropriate way? See 2a1.20 for measure score calculation logic.
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.
Denominator Details	Time Window: A brief, discreet data-collection period is preferred. A data-collection period of between 1-4 weeks is usually sufficient to collect needed data. Staff respondents should include all staff categories, including both clinical and non-clinical staff as well as those in roles such as building/environmental services, food services, etc. A minimum of 50 staff responses in a variety of staff categories is required to calculate the measure score. Staff surveys are made available in English and Spanish by default, with additional language available upon request. Patient respondents include all patients, with a pediatric version made available for families of minor patients. During field testing, patient surveys were available in 5 languages: English, Spanish, Chinese, Polish and Vietnamese. Currently, English and Spanish language surveys are made available by default with additional languages available upon request (languages determined by organization using the C-CAT). During field testing of the instruments, surveys were available on paper or online and during phase 1 patient surveys were also available via automated voice response systems. After very few patients replied using the voice automated system, the system was retired from use.
Exclusions	Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.
Exclusion Details	Based on response to the first item on the staff survey ("Does your job involve direct contact with patients? yes/no"), staff respondents who do not have direct contact with patients are excluded from items that relate to direct contact with patients.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Non-weighted score/composite/scale better quality = higher score
Algorithm	The measure score is an average of the patient and staff components. Calculation of patient component of measure score: Each response of "never" counts as 0; each response of "sometimes" counts as 0.5; each response of "always" counts as 1.0; responses of "not sure" are excluded. A composite score for each item is calculated by summing the total response scores and dividing by the number of valid responses ("not sure" excluded); this operation is repeated for each item; an average of all patient items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the patient component of "cross-cultural communication." For the staff component: Each response of "strongly disagree" counts as 0; each response of "disagree" counts as 0.33; each response of "agree" counts as 0.67; each response of "strongly agree" counts as 1.0. Each response of “very poor” counts as 0; each response of “poor” counts as 0.25; each response of “fair” counts as 0.5; each response of “good” counts as 0.75; each response of “very good” counts as 1.0. Each response of “no training” counts as 0; each response of “inadequate training” counts as 0.5; each response of “adequate training” counts as 1.0. responses of "n/a" or "not sure" are excluded. A composite score for each item is calculated by summing the total response score and dividing by the number of valid responses ("n/a" and "not sure" excluded); this operation is repeated for each item; an average of all staff items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the staff component of the domain of "cross-cultural communication." The average of the staff and patient components is obtained, resulting in the measure score for the domain of "cross-cultural communication."
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	1896 Language services measure derived from the language services domain of CCAT
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	0-100 measure of language services related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit (C-CAT)
Type	Patient Engagement/Experience
Data Source	Healthcare Provider Survey Communication Climate Assessment Toolkit (C-CAT) survey instruments (staff and patient). Available at: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? URL http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? Attachment language services data library.xls
Level	Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
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.
Numerator Details	Time Window: Open data collection period -- ideally all C-CAT data are collected in a discreet data collection period ranging from 1-4 weeks. However, in order to achieve sufficient data sites with smaller patient populations, or those looking to collect data from a specific sub-group (including LEP patients, a key demographic for this measure), may require a longer data-collection period. The measure result is obtained by calculating a 0-100 score for both the patient and staff component of the measure. Item language is adjusted based on whether site is a hospital or clinic. Patient survey items: p7 (pp7): Were the hospital (clinic)'s forms easy for you to fill out? p8 (pp8): Did hospital (clinic) staff offer to help you fill out the forms? p9 (pp9): Did you understand the hospital (clinic)'s informed consent forms? p13 (pp13): Were the educational materials easy to understand? p27 (pp27): Did you understand what hospital (clinic) staff told you over the phone? p46 (pp47): Has someone from the hospital (clinic) asked you what language you speak? p47 (pp48): Do you need an interpreter when you visit the hospital (clinic)? p48 (pp49): Do you prefer to have a family member or friend interpret for you at the hospital (clinic)? p49 (pp50): Has someone from the hospital (clinic) asked if you need an interpreter? p50 (pp51): Does the hospital (clinic) charge patients for using interpreters? p51 (pp52): Were forms written in your language? p52 (pp53): Was it is easy to get an interpreter at the hospital (clinic)? p53 (pp54): Did the hospital (clinic)'s interpreters understand everything you said? p54 (pp55): Were you happy with the hospital (clinic)'s interpreters? Staff survey items: s16: Hospital (clinc) staff members have communicated well with patients over the phone. s19: Hospital (clinic) staff members have needed more time to communicate well with patients. s22: Patients who needed an interpreter were offered one. s23: Patients were charged for using interpreters. s24: The hospital (clinic) tracked how long I waited for interpreters. s25: It was easy to arrange for an interpreter when needed. s26: It was easy to request translated documents. s27: I was encouraged to use trained medical interpreters to discuss informed consent with patients with limited English proficiency. s29: How often did you work with a bilingual staff member who is untrained in interpretation? s30: How often did you work with a trained medical interpreter? s31: How often did you work with a interpreter over the phone (telephonic interpreter)? s32: How often did you work with a patient's adult friend or family?

	s33: How often did you work with a patient's child (under age 18)? s35: During the last 6 months, how often did relevant hospital (clinic) staff ask patients what language they prefer using, when the patients registered or scheduled appointments? s36: How often did relevant hospital (clinic) staff ask patients if they need an interpreter, when the patients registered or scheduled appointments? s37: How often did relevant hospital (clinic) staff have easy access to information on what language patients speak? s38: How often did relevant hospital (clinic) staff have easy access to information on whether patients need an interpreter? s39: How often did relevant hospital (clinic) staff ask patients if they would like help filling out hospital forms? s40: How often did relevant hospital (clinic) staff notice that patients have difficulty filling out hospital forms? s44: Overall, how would you rate the hospital (clinic)'s informed consent forms? s45: Overall, how would you rate the availability of translated documents and forms at the hospital (clinic)? s46: Overall, how would you rate the hospital (clinic)'s interpretation services? s48: Overall, how would you rate the hospital (clinic)'s efforts to help patients access community resources (e.g., assistance with medications, nutrition, insurance, legal aid, etc.)? s52: Have you ever received specific and adequate training on communication policies at the hospital (clinic)? s53: Have you ever received specific and adequate training on the impact of miscommunication on patient safety? s60: Have you ever received specific and adequate training on finding out when patients need an interpreter? s61: Have you ever received specific and adequate training on how to work with interpreters effectively? s63: Effective medical interpretation requires specialized training. s64: A patient's family member or friend can usually interpret as effectively as a trained medical interpreter. See 2a1.20 for measure score calculation logic.
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
Denominator Details	Time Window: A brief, discreet data-collection period is preferred. A data-collection period of between 1-4 weeks is usually sufficient to collect needed data. as well as those in roles such as building/environmental services, food services, etc. A minimum of 50 staff responses in a variety of staff categories is required to calculate the measure score. Staff surveys are made available in English and Spanish by default, with additional language available upon request. Patient respondents include all patients, with a pediatric version made available for families of minor patients. During field testing, patient surveys were available in 5 languages: English, Spanish, Chinese, Polish and Vietnamese. Currently, English and Spanish language surveys are made available by default with additional languages available upon request (languages determined by organization using the measure). During field testing of the instruments, surveys were available on paper or online and during phase 1 patient surveys were also available via automated voice response systems. After very few patients replied using the voice automated system, the system was retired from use.
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.
Exclusion Details	Patients who report a preference for speaking English with their doctors (p44., In what language would you like to talk to your doctor?" are excluded on items that reference translation and interpretation services. Items excluded are: p46 (pp47). Has someone from the hospital (clinic) asked you what language you speak? p47 (pp48). Do you need an interpreter when you visit the hospital (clinic)? p48 (pp49). Do you prefer to have a family member or friend interpret for you at the hospital (clinic)? p49 (pp50). Has someone from the hospital (clinic) asked if you need an interpreter? p50 (pp51). Does the hospital (clinic) charge patients for using interpreters? p51 (pp52). Were forms written in your language? p52 (pp53). Was it is easy to get an interpreter at the hospital (clinic)? p53 (pp54). Did the hospital (clinic)'s interpreters understand everything you said? p54 (pp55). Were you happy with the hospital (clinic)'s interpreters?

Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Non-weighted score/composite/scale better quality = higher score
Algorithm	The measure score is an average of the patient and staff components. Calculation of patient component of measure score: Each response of “yes” counts as 1; each response of “no” counts as 0; responses of “not sure” are excluded. Additionally, responses on items p46-p54 are excluded for those who report a preference for speaking English on p44 (“In what language would you like to talk to your doctor?”). each response of "never" counts as 0; each response of "sometimes" counts as 0.5; each response of "always" counts as 1.0; responses of "not sure" are excluded. A composite score for each item is calculated by summing the total response scores and dividing by the number of valid responses ("not sure" excluded); this operation is repeated for each item; an average of all patient items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the patient component of "language services." For the staff component: Each response of “never” counts as 0; each response of “rarely” counts as 0.25; each response of “sometimes” counts as 0.5; each response of “often” counts as 0.75; each response of “always” counts as 1.0. Each response of “very poor” counts as 0; each response of “poor” counts as 0.25; each response of “fair” counts as 0.5; each response of “good” counts as 0.75; each response of “very good” counts as 1.0. Each response of “no training” counts as 0; each response of “inadequate training” counts as 0.5; each response of “adequate training” counts as 1.0. Each response of "strongly disagree" counts as 0; each response of "disagree" counts as 0.33; each response of "agree" counts as 0.67; each response of "strongly agree" counts as 1.0; responses of "n/a" or "not sure" are excluded. A composite score for each item is calculated by summing the total response score and dividing by the number of valid responses ("n/a" and "not sure" excluded); this operation is repeated for each item; an average of all staff items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the staff component of the domain of "language services."
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	1898 Health literacy measure derived from the health literacy domain of CCAT
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	0-100 measure of health literacy related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit
Type	Patient Engagement/Experience
Data Source	Healthcare Provider Survey Communication Climate Assessment Toolkit (C-CAT) survey instruments (staff and patient). Available at: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? URL http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? Attachment health literacy data library.xls
Level	Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
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.
Numerator Details	Time Window: Open data collection period -- ideally all C-CAT data are collected in a discreet data collection period ranging from 1-4 weeks. However, in order to achieve sufficient data sites with smaller patient populations, or those looking to collect data from a specific sub-group, may require a longer data-collection period. The measure result is obtained by calculating a 0-100 score for both the patient and staff component of the measure. Item language is adjusted based on whether site is a hospital or clinic. Patient survey items: p2 (pp2): Could you find your way around the hospital (clinic)? p3 (pp3): Could you understand the hospital (clinic)'s signs and maps? p6 (pp6): Was it easy to ask questions at the hospital (clinic)? p7 (pp7): Were the hospital (clinic)'s forms easy for you to fill out? p8 (pp8): Did hospital (clinic) staff offer to help you fill out the forms? p9 (pp9): Did you understand the hospital (clinic)'s informed consent forms? p13 (pp13): Were the educational materials easy to understand? p16 (pp16): Did doctors explain things in a way you could understand? p17 (pp17): Did doctors ask you to repeat their instructions? p21 (pp21): Did doctors ask if you had any questions? p23 (pp23): Did you know your main health problem? p24 (pp24): Did you understand your doctor's instructions? p25 (pp25): Did you know how to take your medicine? p27 (pp27): Did you understand what hospital (clinic) staff told you over the phone? p29 (pp29): Do you feel welcome at the hospital (clinic)? Staff survey items: s1: Senior leaders have taken steps to create a more welcoming environment for patients. s6: My direct supervisors have intervened if staff were not respectful towards patients. s16: Hospital (clinic) staff members have communicated well with patients over the phone. s19: Hospital (clinic) staff members have needed more time to communicate well with patients. s39: During the last 6 months, how often did relevant hospital (clinic) staff ask patients if they would like help filling out hospital forms? s42: Overall, how would you rate the understandability of the hospital (clinic)'s patient education materials? s43: Overall, how would you rate the signs and maps at the hospital (clinic)? s44: Overall, how would you rate the hospital (clinic)'s informed consent forms?

	s48: Overall, how would you rate the hospital (clinic)'s efforts to help patients access community resources (e.g., assistance with medications, nutrition, insurance, legal aid, etc.)? s52: Have you ever received specific and adequate training on communication policies at the hospital (clinic)? s53: Have you ever received specific and adequate training on the impact of miscommunication on patient safety? s54: Have you ever received specific and adequate training on the importance of communicating with patients in plain language instead of using technical terms? s55: Have you ever received specific and adequate training on ways to check whether patients understand instructions (such as the teach-back or the "show-me" methods)? See field 2a1.20 for measure score calculation logic.
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.
Denominator Details	Time Window: A brief, discreet data-collection period is preferred. A data-collection period of between 1-4 weeks is usually sufficient to collect needed data. Staff respondents should include all staff categories, including both clinical and non-clinical staff as well as those in roles such as building/environmental services, food services, etc. A minimum of 50 staff responses in a variety of staff categories is required to calculate the measure score. Staff surveys are made available in English and Spanish by default, with additional language available upon request. Patient respondents include all patients, with a pediatric version made available for families of minor patients. During field testing, patient surveys were available in 5 languages: English, Spanish, Chinese, Polish and Vietnamese. Currently, English and Spanish language surveys are made available by default with additional languages available upon request (languages determined by organization using the C-CAT). During field testing of the instruments, surveys were available on paper or online and during phase 1 patient surveys were also available via automated voice response systems. After very few patients replied using the voice automated system, the system was retired from use.
Exclusions	Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.
Exclusion Details	Based on response to the first item on the staff survey ("Does your job involve direct contact with patients? yes/no"), staff respondents who do not have direct contact with patients are excluded from items that relate to direct contact with patients.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Non-weighted score/composite/scale better quality = higher score
Algorithm	The measure score is an average of the patient and staff components. Calculation of patient component of measure score: each response of "never" counts as 0; each response of "sometimes" counts as 0.5; each response of "always" counts as 1.0; responses of "not sure" are excluded. A composite score for each item is calculated by summing the total response scores and dividing by the number of valid responses ("not sure" excluded); this operation is repeated for each item; an average of all patient items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the patient component of "health literacy." For the staff component: Each response of "never" counts as 0; each response of "rarely" counts as 0.25; each response of "sometimes" counts as 0.5; each response of "often" counts as 0.75; each response of "always" counts as 1.0. Each response of "very poor" counts as 0; each response of "poor" counts as 0.25; each response of "fair" counts as 0.5; each response of "good" counts as 0.75; each response of "very good" counts as 1.0. Each response of "no training" counts as 0; each response of "inadequate training" counts as 0.5; each response of "adequate training" counts as 1.0. For items s1, s6, s16, and s39 responses of "strongly disagree" counts as 0; each response of "disagree" counts as 0.33; each response of "agree" counts as 0.67; each response of "strongly agree" counts as 1.0; item s19 is reverse-coded, so that each response of "strongly disagree counts as 1.0, each response of "disagree" counts as 0.67, each response of "agree" counts as 0.33, and each response of "strongly agree" counts as 1.0. responses of "n/a" or "not sure" are excluded. A composite score for each item is calculated by summing the total response score and dividing by the number of valid responses ("n/a" and "not sure" excluded); this operation is repeated for each item; an average of all staff items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the staff component of the domain of "health literacy."

	The average of the staff and patient components is obtained, resulting in the measure score for the domain of "health literacy."
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	1901 Performance evaluation measure derived from the performance evaluation domain of CCAT
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	0-100 measure of performance evaluation related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit
Type	Patient Engagement/Experience
Data Source	Healthcare Provider Survey Communication Climate Assessment Toolkit (C-CAT) survey instruments (staff and patient). Available at: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page URL http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? Attachment Performance evaluation data library.xls
Level	Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
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.
Numerator Details	Time Window: Open data collection period -- ideally all C-CAT data are collected in a discreet data collection period ranging from 1-4 weeks. However, in order to achieve sufficient data sites with smaller patient populations, or those looking to collect data from a specific sub-group, may require a longer data-collection period. The measure result is obtained by calculating a 0-100 score for both the patient and staff component of the measure. Item language is adjusted based on whether site is a hospital or clinic. Patient item: p28 (pp28): Did you know whom to call if you wanted to complain? Staff items: s5: Senior leaders have rewarded staff and departments that work to improve communication. s6: My direct supervisors have intervened if staff were not respectful towards patients. s7: My direct supervisors have monitored whether I communicate effectively with patients. s9: My direct supervisors have asked for my suggestions on how to improve communication within the hospital (clinic). s10: My direct supervisors have used my feedback to improve communication within the hospital (clinic). s14: Hospital (clinic) staff members have spoken openly with supervisors about any miscommunication. s15: Hospital (clinic) staff members have known whom to call if they have a problem or suggestion. See field 2a1.20 for measure score calculation logic.
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.
Denominator Details	Time Window: A brief, discreet data-collection period is preferred. A data-collection period of between 1-4 weeks is usually sufficient to collect needed data. Staff respondents should include all staff categories, including both clinical and non-clinical staff as well as those in roles such as building/environmental services, food services, etc. A minimum of 50 staff responses in a variety of staff categories is required to calculate the measure score. Staff surveys are made available in English and Spanish by default, with additional language available upon request. Patient respondents include all patients, with a pediatric version made available for families of minor patients. During field testing, patient surveys were available in 5 languages: English, Spanish, Chinese, Polish and Vietnamese. Currently, English and Spanish language surveys are made available by default with additional languages available upon request (languages determined by organizations using the C-CAT). During field testing of the instruments, surveys were available on paper or online and during phase 1 patient surveys were also available via automated voice response systems. After very few patients replied using the voice automated system, the system was retired from use.
Exclusions	Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.

Exclusion Details	Based on response to the first item on the staff survey ("Does your job involve direct contact with patients? yes/no"), staff respondents who do not have direct contact with patients are excluded from items that relate to direct contact with patients.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Non-weighted score/composite/scale better quality = higher score
Algorithm	The measure score is an average of the patient and staff components. Calculation of patient component of measure score: each response of "never" counts as 0; each response of "sometimes" counts as 0.5; each response of "always" counts as 1.0; responses of "not sure" are excluded. A composite score for each item is calculated by summing the total response scores and dividing by the number of valid responses ("not sure" excluded); this operation is repeated for each item; an average of all patient items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the patient component of "performance evaluation." For the staff component: each response of "strongly disagree" counts as 0; each response of "disagree" counts as 0.33; each response of "agree" counts as 0.67; each response of "strongly agree" counts as 1.0; responses of "n/a" or "not sure" are excluded. A composite score for each item is calculated by summing the total response score and dividing by the number of valid responses ("n/a" and "not sure" excluded); this operation is repeated for each item; an average of all staff items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the staff component of the domain of "performance evaluation." The average of the staff and patient components is obtained, resulting in the measure score for the domain of performance evaluation regarding patient-centered community.
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	1905 Leadership commitment measure derived from the leadership commitment domain of CCAT
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	0-100 measure of leadership commitment to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit
Type	Patient Engagement/Experience
Data Source	Healthcare Provider Survey, Patient Reported Data/Survey Communication Climate Assessment Toolkit (C-CAT) survey instruments (staff and patient). Available at: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? URL http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? Attachment Leadership commitment data library-634625039647599664.xls
Level	Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
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
Numerator Details	Time Window: Open data collection period -- ideally all C-CAT data are collected in a discreet data collection period ranging from 1-4 weeks. However, in order to achieve sufficient data sites with smaller patient populations, or those looking to collect data from a specific sub-group, may require a longer data-collection period. The measure result is obtained by calculating a 0-100 score for both the patient and staff component of the measure. Item language is adjusted based on whether site is a hospital or clinic. Patient survey items: p6. Was it easy to ask questions at the hospital (clinic)? p10. Was information in the waiting areas helpful? p26. Was it easy to reach someone on the phone if you had a question? p29. Do you feel welcome at the hospital (clinic)? p30. Are you happy with the care you get at the hospital (clinic)? p31. Does the hospital (clinic) communicate well with patients? p34. Would you bring a family member to this hospital (clinic)? Staff survey items: s1. Senior leaders have taken steps to create a more welcoming environment for patients. s2. Senior leaders have taken steps to promote a more patient-centered environment. s3. Senior leaders have made effective communication with diverse populations a priority. s5. Senior leaders have rewarded staff and departments that work to improve communication. s6. My direct supervisors have intervened if staff were not respectful towards patients. s9. My direct supervisors have asked for my suggestions on how to improve communication within the hospital (clinic). s10. My direct supervisors have used my feedback to improve communication within the hospital (clinic). s13. Hospital (clinic) staff members have shown that they care about communicating effectively with diverse populations. s14. Hospital (clinic) staff members have spoken openly with supervisors about any miscommunications.

	s15. Hospital (clinic) staff members have known whom to call if they have a problem or suggestion. s16. Hospital (clinic) staff members have communicated well with patients over the phone. s17. Hospital (clinic) staff members have communicated with each other respectfully. s18. Hospital (clinic) staff members have communicated with each other effectively to ensure high quality care. s19. Hospital (clinic) staff members have needed more time to communicate well with patients. s52. Have you ever received specific and adequate training on communication policies at the hospital (clinic)? s53. Have you ever received specific and adequate training on the impact of miscommunication on patient safety? See field 2a1.20 for measure score calculation logic.
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.
Denominator Details	Time Window: A brief, discreet data-collection period is preferred. A data-collection period of between 1-4 weeks is usually sufficient to collect needed data. Staff respondents should include all staff categories, including both clinical and non-clinical staff as well as those in roles such as building/environmental services, food services, etc. A minimum of 50 staff responses in a variety of staff categories is required to calculate the measure score. Staff surveys are made available in English and Spanish by default, with additional language available upon request. Patient respondents include all patients, with a pediatric version made available for families of minor patients. During field testing, patient surveys were available in 5 languages: English, Spanish, Chinese, Polish and Vietnamese. Currently, English and Spanish language surveys are made available by default with additional languages available upon request (languages determined by organization using the C-CAT). During field testing of the instruments, surveys were available on paper or online and during phase 1 patient surveys were also available via automated voice response systems. After very few patients replied using the voice automated system, the system was retired from use.
Exclusions	Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.
Exclusion Details	Based on response to the first item on the staff survey ("Does your job involve direct contact with patients? yes/no"), staff respondents who do not have direct contact with patients are excluded from items that relate to direct contact with patients.
Risk Adjustment	N/A
Stratification	N/A
Type Score	Non-weighted score/composite/scale better quality = higher score
Algorithm	The measure score is an average of the patient and staff components. Calculation of patient component of measure score: each response of "never" counts as 0; each response of "sometimes" counts as 0.5; each response of "always" counts as 1.0; responses of "not sure" are excluded. A composite score for each item is calculated by summing the total response scores and dividing by the number of valid responses ("not sure" excluded); this operation is repeated for each item; an average of all patient items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the patient component of "leadership commitment." For the staff component: each response of "strongly disagree" counts as 0; each response of "disagree" counts as 0.33; each response of "agree" counts as 0.67; each response of "strongly agree" counts as 1.0; responses of "n/a" or "not sure" are excluded. A composite score for each item is calculated by summing the total response score and dividing by the number of valid responses ("n/a" and "not sure" excluded); this operation is repeated for each item; an average of all staff items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the staff component of the domain of "leadership commitment." The average of the staff and patient components is obtained, resulting in the measure score for the domain of leadership commitment to patient-centered community.
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	1919 Cultural Competency Implementation Measure
Steward	RAND Corporation
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.
Type	Patient Engagement/Experience
Data Source	Healthcare Provider Survey N/A URL https://www.randsurvey.org/ccis/ URL https://www.randsurvey.org/ccis/
Level	Facility, Health Plan, Integrated Delivery System
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Dialysis Facility, Hospice, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
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.
Numerator Details	**Time Window:** The questions included in the survey ask the responding organization to report whether they have implemented or adopted various actions in support of one of the 12 cultural competence preferred practices covered in the survey by choosing one of 5 response options (no; yes, withing the last 12 months; yes, withing the last 13-24 months; yes, withing the last 25=36 months; and yes, more than 36 months ago). For certain questions where the NQF preferred practice statement specifically indicates that an activity or practice has to be implemented in the last 12 months, the survey question uses a 12-month reference period. The survey can be used across health care settings with different types of health care organizations. The survey includes a section designed to collect information that describes the organization completing the survey (organization name, telephone number, organization type, organization part of a larger health care system and if yes, the name of the system, name of CEO, name of person completing the survey, title, telephone number, email address).
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.
Denominator Details	**Time Window:** The survey asks participating organization to report on activities they have engaged in, in order to adopt of implement the 12 NQF-endorsed practices covered by the survey, using one of 5 response options (no; yes, withing the last 12 months; yes, withing the last 13-24 months; yes, withing the last 25=36 months; and yes, more than 36 months ago). For certain questions where the NQF preferred practice statement specifically indicates that an activity or practice has to be implemented in the last 12 months, the survey question uses a 12-month reference period. In order to identify and calculate the target population, survey users must clearly identify the type of health care organizations they aim to include in the survey, and the number of organizations by type they are including in the survey.
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.
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	better quality = higher score
Algorithm	The Cultural Competency Implementation Measure is specifically designed to collect information on an organization's progress on 12 of the NQF-endorsed® cultural competency practices. Each practice is assigned an individual weight, which is factored into the overall score. The aim is to rank organizations by quartiles based on their relative progress out of the total number of possible points. The scales associated with each of the preferred cultural competency practices that are covered by the survey are weighted differently for purposes of scoring but equal weighting is used for the survey items that comprise the scale. The maximum number of points for each scale based on the relative impact of the cultural competency practice with which it is associated. Table 3 below provides an overview of the scoring for each of the practices covered by the survey. The maximum number of points for all practices combined is 142. Table 3 Scoring by Preferred Practice Practice Name and Number Weighting (pts) Preferred Practice 12: 19 points Preferred Practice 5: 17 points Preferred Practice 4: 14 points Preferred Practice 3: 13 points Preferred Practice 30: 11 points Preferred Practice 32: 11 points Preferred Practice 40: 12 points Preferred Practice 23: 10 points Preferred Practice 37: 11 points Preferred Practice 43: 11 points Preferred Practice 8: 8 points Preferred Practice 10: 5 points TOTAL POINTS 142 As mentioned above, within the scale for each practice, each question has an equal point value, computed as the maximum points for that scale divided by the number of questions that an organization provided a response for in that scale. Item response categories for each question are scored as follows: • No=0 • Yes, within the last 12 months=100 • Yes, within the last 12 months=75 • Yes, within the last 12 months=50 • Yes, within the last 12 months=25 Survey items for which a respondent can select more than one response option are scored as follows: • No=0 • If 1 yes checked=1 • If 2 yes checked=2 • If 3 yes checked=3 Scores are then transformed linearly to 0-100 possible range, resulting in scores of approximately 0, 33.33, 66.66, and 100. The overall score for a survey is the sum of all the points earned for each of the scales included in the survey. The sum of the points earned across all scales in the survey is multiplied by the ratio of 142 maximum points to the sum of available points for each practice. All survey scores will be normalized to 100. All organizations that complete a survey are stratified into quartiles based on their overall points. In order to receive the highest level of recognition, an organization must be in the top quartile of responding organizations in terms of their overall points. Attachment NQF_Survey_FinalReport_23DEC11_tp.pdf
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APPENDIX B: STEERING COMMITTEE and NQF STAFF

STEERING COMMITTEE

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Cultural Competency

	1919 Cultural Competency Implementation Measure	1904 Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	1894 Cross-cultural communication measure derived from the cross-cultural communication domain of the C-CAT
Steward	RAND Corporation	Agency for Healthcare Research and Quality	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
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.	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).	0-100 measure of cross-cultural communication related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit
Type	Patient Engagement/Experience	Patient Engagement/Experience	Patient Engagement/Experience
Data Source	Healthcare Provider Survey N/A URL https://www.randsurvey.org/ccis/ URL https://www.randsurvey.org/ccis/	Patient Reported Data/Survey CAHPS Cultural Competence Item Set. Below is listed the complete item set, including items that are not measures and items from the core Clinician and Group CAHPS that can be use for stratification and analytic purposes. Core 1. Our records show that you got care from the provider named below in the last 12 months. Name of provider label goes here Is that right? __ Yes __ No If No, go to #core question 26	Healthcare Provider Survey Communication Climate Assessment Toolkit (C-CAT) survey instruments (staff and patient). Available at: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page URL http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? Attachment

	1919 Cultural Competency Implementation Measure	1904 Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	1894 Cross-cultural communication measure derived from the cross-cultural communication domain of the C-CAT
		CU1. In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English? __ Never __ Sometimes __ Usually __ Always CU2. In the last 12 months, how often did this provider use medical words you did not understand? __ Never __ Sometimes __ Usually __ Always CU3. In the last 12 months, how often did this provider talk too fast when talking with you? __ Never __ Sometimes __ Usually __ Always CU4. In the last 12 months, how often did this provider ignore what you told him or her? __ Never __ Sometimes __ Usually __ Always CU5. In the last 12 months, how often did this provider interrupt you when you were talking? __ Never __ Sometimes __ Usually __ Always CU6. In the last 12 months, how often did this provider show interest in your questions and concerns? __ Never __ Sometimes __ Usually __ Always	cross-cultural communication data library.xls

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		CU7. In the last 12 months, how often did this provider answer all your questions to your satisfaction? __ Never __ Sometimes __ Usually __ Always CU8. In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? __ Never __ Sometimes __ Usually __ Always CU9. People sometimes see someone else besides their providers or specialists to help with an illness or to stay healthy. In the last 12 months, have you ever used an acupuncturist? __ Yes __ No CU10. In the last 12 months, have you ever used an herbalist? __ Yes __ No CU11. In the last 12 months, has this provider ever asked you if you have used an acupuncturist or an herbalist to help with an illness or to stay healthy? __ Yes __ No CU12. Some people use natural herbs for health reasons or to stay healthy. Natural herbs include things such as ginseng, green tea, and other herbs. People can take them as a pill, a tea, oil, or a powder. In the last 12 months, have you ever used natural herbs for your own health? __ Yes __ No CU13. In the last 12 months, has this provider ever asked you if you used natural herbs? __ Yes	

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		__ No CU14. In the last 12 months, how often have you been treated unfairly at this provider´s office because of your race or ethnicity? __ Never __ Sometimes __ Usually __ Always CU15. In the last 12 months, how often have you been treated unfairly at this provider´s office because of the type of health insurance you have or because you do not have health insurance? __ Never __ Sometimes __ Usually __ Always CU16. In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else? __ Yes, definitely __ Yes, somewhat __ No CU17. In the last 12 months, did you feel you could trust this provider with your medical care? __ Yes, definitely __ Yes, somewhat __ No CU18. In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news? __ Yes, definitely __ Yes, somewhat __ No CU19. In the last 12 months, did you feel this provider cared as much as you do about your health? __ Yes, definitely __ Yes, somewhat __ No CU20. In the last 12 months, did you feel this provider	

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		really cared about you as a person? __ Yes, definitely __ Yes, somewhat __ No CU21. Using any number from 0 to 10, where 0 means that you do not trust this provider at all and 10 means that you trust this provider completely, what number would you use to rate how much you trust this provider? __ 0 Do not trust this provider at all __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 Trust this provider completely CU22. What is your preferred language? __ English If English, go to #core question 24 __ American Sign Language __ [INSERT LANGUAGE 1] __ [INSERT LANGUAGE 2] __ [INSERT LANGUAGE 3] __ [INSERT LANGUAGE 4] __ [INSERT LANGUAGE 5] __ [INSERT LANGUAGE 6] __ [INSERT LANGUAGE 7] __ [INSERT LANGUAGE 8] __ [INSERT LANGUAGE 9] __ Other CU23. How well do you speak English? __ Very well If Very well, go to #CU25 __ Well __ Not well __ Not at all CU24. In the last 12 months, how often were you treated unfairly because you did not speak English very	

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		well? __ Never __ Sometimes __ Usually __ Always CU25. An interpreter is someone who helps you talk with others who do not speak your language. Interpreters can include staff from the doctor's office or telephone interpreters. In the last 12 months, was there any time when you needed an interpreter at this doctor's office? __ Yes __ No If No, go to ## CU33 CU26. In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge? __ Yes __ No CU27. In the last 12 months, how often did you use an interpreter provided by this office to help you talk with this provider? __ Never If Never, go to #CU33 __ Sometimes __ Usually __ Always CU28. In the last 12 months, when you used an interpreter provided by this office who was the interpreter you used most often? __ A nurse, clerk, or receptionist from this office __ An interpreter provided in-person by this office __ A telephone interpreter provided by this office __ Someone else provided by this office CU29. In the last 12 months, how often did this interpreter treat you with courtesy and respect? __ Never __ Sometimes __ Usually __ Always CU30. Using any number from 0 to 10, where 0 is the	

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		worst interpreter possible and 10 is the best interpreter possible, what number would you use to rate this interpreter? __ 0 Worst interpreter possible __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 Best interpreter possible CU31. In the last 12 months, did any of your appointments with this provider start late? __ Yes __ No If No, go to #CU33 CU32. Did any of your appointments start late because you had to wait for an interpreter? __ Yes __ No CU33. In the last 12 months, how often did you use a friend or family member as an interpreter when you talked with this doctor? __ Never If Never, go to #core question 24 __ Sometimes __ Usually __ Always CU34. In the last 12 months, did you use friends or family members as interpreters because that was what you preferred? __ Yes __ No Core 26. In general, how would you rate your overall health? __ Excellent __ Very good	

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		__ Good __ Fair __ Poor Core 27. In general, how would you rate your overall mental or emotional health? __ Excellent __ Very Good __ Good __ Fair __ Poor Core 28. What is your age? __ 18 to 24 __ 25 to 34 __ 35 to 44 __ 45 to 54 __ 55 to 64 __ 65 to 74 __ 75 or older Core 29. Are you male or female? __ Male __ Female Core 30. What is the highest grade or level of school that you have completed? __ 8th grade or less __ Some high school, but did not graduate __ High school graduate or GED __ Some college or 2-year degree __ 4-year college graduate __ More than 4-year college degree Core 31. Are you of Hispanic or Latino origin or descent? __ Yes, Hispanic or Latino __ No, not Hispanic or Latino Core 32. What is your race? Mark one or more. __ White __ Black or African American __ Asian __ Native Hawaiian or Other Pacific Islander __ American Indian or Alaska Native __ Other	

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		Core 33. Did someone help you complete this survey? __ Yes __ No Thank you. Please return the completed survey in the postage-paid envelope. Core 34. How did that person help you? Mark one or more. __ Read the questions to me __ Wrote down the answers I gave __ Answered the questions for me __ Translated the questions into my language __ Helped in some other way Please print:___________________________ ____ ____ Attachment --HPS_Cultural_Competence_Item_Set_3-19-12.docx	
Level	Facility, Health Plan, Integrated Delivery System	Clinician : Group/Practice, Clinician : Individual	Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Dialysis Facility, Hospice, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
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.	We recommend that the Clinicians/Groups' Cultural Competence 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).	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.
Numerator Details	Time Window: The questions included in the survey ask the responding organization to report whether they have implemented or adopted various actions in support of one	Time Window: Last 12 months Top Box Method: Calculate the number of responses in	Time Window: Open data collection period -- ideally all C-CAT data are collected in a discreet data collection period ranging from 1-4 weeks. However, in order to achieve

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	of the 12 cultural competence preferred practices covered in the survey by choosing one of 5 response options (no; yes, withing the last 12 months; yes, withing the last 13-24 months; yes, withing the last 25=36 months; and yes, more than 36 months ago). For certain questions where the NQF preferred practice statement specifically indicates that an activity or practice has to be implemented in the last 12 months, the survey question uses a 12-month reference period. The survey can be used across health care settings with different types of health care organizations. The survey includes a section designed to collect information that describes the organization completing the survey (organization name, telephone number, organization type, organization part of a larger health care system and if yes, the name of the system, name of CEO, name of person completing the survey, title, telephone number, email address).	the most positive response category for each item. Below each item is listed with the most positive response indicated in parentheses. Note that for CU1, CU2, CU3, CU4, CU5, CU14, CU15, CU24, and CU33 the most positive response is "Never." Specific instructions for how reverse coding can be done in SAS can be found in "Instructions for Analyzing CAHPS Data" (available at: https://www.cahps.ahrq.gov/Surveys-Guidance/Dental/~/media/Files/SurveyDocuments/Dental/Prep_Analyze/2015_instructions_for_analyzing_data.pdf) in the section called "Data Set Specification." CU1 In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English? (Never) CU2 In the last 12 months, how often did this provider use medical words you did not understand? (Never) CU3 In the last 12 months, how often did this provider talk too fast when talking with you? (Never) CU4 In the last 12 months, how often did this provider ignore what you told him or her? (Never) CU5 In the last 12 months, how often did this provider interrupt you when you were talking? (Never) CU6 In the last 12 months, how often did this provider show interest in your questions and concerns? (Always) CU7 In the last 12 months, how often did this provider answer all your questions to your satisfaction? (Always) CU8 In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Never) CU11 In the last 12 months, has this provider ever asked you if you have used an acupuncturist or an herbalist to help with an illness or to stay healthy? (Yes) CU13 In the last 12 months, has this provider ever asked you if you used natural herbs? (Yes) CU14 In the last 12 months, how often have you been treated unfairly at this provider´s office because of your race or ethnicity? (Never) CU15 In the last 12 months, how often have you been	sufficient data sites with smaller patient populations, or those looking to collect data from a specific sub-group, may require a longer data-collection period. The measure result is obtained by calculating a 0-100 score for both the patient and staff component of the measure. Item language is adjusted based on whether site is a hospital or clinic. Patient survey items: p16 (pp16): Did doctors explain things in a way you could understand? p19 (pp19): Did doctors at the hospital (clinic) try to understand your culture? p20 (pp20): Could you talk to your doctors about home remedies? Staff survey items: s1: Senior leaders have taken steps to create a more welcoming environment for patients. s2: Senior leaders have taken steps to promote a more patient-centered environment. s6: My direct supervisors have intervened if staff were not respectful towards patients. s12: My direct supervisors have encouraged me to talk with patients about cultural and spiritual beliefs that might influence their health care. s13: Hospital (clinic) staff members have shown that they care about communicating effectively with diverse populations. s16: Hospital (clinic) staff members have communicated well with patients over the phone. s17: Hospital (clinic) staff members have communicated with each other respectfully. s19: Hospital (clinic) staff members have needed more time to communicate well with patients. s41: Overall, how would you rate the cultural appropriateness of the hospital (clinic)'s patient education materials? s44: Overall, how would you rate the hospital (clinic)'s

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		treated unfairly at this provider´s office because of the type of health insurance you have or because you don´t have health insurance? (Never) CU16 In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else? (Yes, definitely) CU17 In the last 12 months, did you feel you could trust this provider with your medical care? (Yes, definitely) CU18 In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news? (Yes, definitely) CU19 In the last 12 months, did you feel this provider cared as much as you do about your health? (Yes, definitely) CU20 In the last 12 months, did you feel this provider really cared about you as a person? (Yes, definitely) CU21 Using any number from 0 to 10, where 0 means that you do not trust this provider at all and 10 means that you trust this provider completely, what number would you use to rate how much you trust this provider? (9-10) CU24. In the last 12 months, how often were you treated unfairly because you did not speak English very well? (Never) CU26 In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge? (Yes) CU27 In the last 12 months, how often did you use an interpreter provided by this office to help you talk with this provider? (Always) CU29 In the last 12 months, how often did this interpreter treat you with courtesy and respect? (Always) CU30 Using any number from 0 to 10, where 0 is the worst interpreter possible and 10 is the best interpreter possible, what number would you use to rate this interpreter? (9-10) CU32 Did any of your appointments start late because you had to wait for an interpreter? (No) CU33 In the last 12 months, how often did you use	informed consent forms? s48: Overall, how would you rate the hospital (clinic)'s efforts to help patients access community resources (e.g., assistance with medications, nutrition, insurance, legal aid, etc.)? s52: Have you ever received specific and adequate training on communication policies at the hospital (clinic)? s53: Have you ever received specific and adequate training on the impact of miscommunication on patient safety? s56: Have you ever received specific and adequate training on interacting with patients from diverse cultural and spiritual backgrounds? s57: Have you ever received specific and adequate training on how to ask patients about their health care values and beliefs? s58: Have you ever received specific and adequate training on how to ask patients about their racial/ethnic background in a culturally appropriate way? See 2a1.20 for measure score calculation logic.

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		friends or family members as interpreters? (Never) CU34 In the last 12 months, did you use friends or family members as interpreters because that was what you preferred? (Yes)	
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.	Adults with a visit to the provider for which the survey is being fielded within the last 12 months who responded to the item.	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.
Denominator Details	Time Window: The survey asks participating organization to report on activities they have engaged in, in order to adopt of implement the 12 NQF-endorsed practices covered by the survey, using one of 5 response options (no; yes, withing the last 12 months; yes, withing the last 13-24 months; yes, withing the last 25=36 months; and yes, more than 36 months ago). For certain questions where the NQF preferred practice statement specifically indicates that an activity or practice has to be implemented in the last 12 months, the survey question uses a 12-month reference period. In order to identify and calculate the target population, survey users must clearly identify the type of health care organizations they aim to include in the survey, and the number of organizations by type they are including in the survey.	Time Window: Last 12 months The denominator is the total number of respondents who selected a response option to a particular item. Respondents may have not answered an item because of a screener that skipped them over that item, or because they chose to skip that question.	Time Window: A brief, discreet data-collection period is preferred. A data-collection period of between 1-4 weeks is usually sufficient to collect needed data. Staff respondents should include all staff categories, including both clinical and non-clinical staff as well as those in roles such as building/environmental services, food services, etc. A minimum of 50 staff responses in a variety of staff categories is required to calculate the measure score. Staff surveys are made available in English and Spanish by default, with additional language available upon request. Patient respondents include all patients, with a pediatric version made available for families of minor patients. During field testing, patient surveys were available in 5 languages: English, Spanish, Chinese, Polish and Vietnamese. Currently, English and Spanish language surveys are made available by default with additional languages available upon request (languages determined by organization using the C-CAT). During field testing of the instruments, surveys were available on paper or online and during phase 1 patient surveys were also available via automated voice response systems. After very few patients replied using the voice automated system, the system was retired from use.
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.	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	Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.

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		the provider in the last 12 months.	
Exclusion Details	N/A	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.	Based on response to the first item on the staff survey ("Does your job involve direct contact with patients? yes/no"), staff respondents who do not have direct contact with patients are excluded from items that relate to direct contact with patients.
Risk Adjustment	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification not applicable	No risk adjustment or risk stratification N/A
Stratification	N/A	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.	N/A
Type Score	better quality = higher score	Non-weighted score/composite/scale better quality = higher score	Non-weighted score/composite/scale better quality = higher score
Algorithm	The Cultural Competency Implementation Measure is specifically designed to collect information on an organization's progress on 12 of the NQF-endorsed® cultural competency practices. Each practice is assigned an individual weight, which is factored into the overall score. The aim is to rank organizations by quartiles based on their relative progress out of the total number of possible points. The scales associated with each of the preferred cultural competency practices that are covered by the survey are weighted differently for purposes of scoring but equal weighting is used for the survey items that comprise the scale. The maximum number of points for each scale based on the relative impact of the cultural competency practice with which it is associated. Table 3 below provides an overview of the scoring for each of the practices covered by the survey. The maximum number of points for all practices combined is 142. Table 3 Scoring by Preferred Practice Practice Name and Number Weighting (pts) Preferred Practice 12: 19 points Preferred Practice 5: 17 points Preferred Practice 4: 14 points	Composites can be calculated for an individual provider (e.g., a doctor), or for a practice or clinic. The Providers Are Caring and Inspire Trust Composite consists of 5 items in the composite: CU16. In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else? (Response: Never/Sometimes/Usually/Always) CU17. In the last 12 months, did you feel you could trust this provider with your medical care? (Response: N/S/U/A) CU18. In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news? (Response: N/S/U/A) CU19. In the last 12 months, did you feel this provider cared as much as you do about your health? (Response: N/S/U/A) CU20. In the last 12 months, did you feel this provider really cared about you as a person? (Response: N/S/U/A) The Providers Are Polite and Considerate Composite consists of 3 items: CU3. In the last 12 months, how often did this provider talk too fast when talking with you? (Response: N/S/U/A)	The measure score is an average of the patient and staff components. Calculation of patient component of measure score: Each response of "never" counts as 0; each response of "sometimes" counts as 0.5; each response of "always" counts as 1.0; responses of "not sure" are excluded. A composite score for each item is calculated by summing the total response scores and dividing by the number of valid responses ("not sure" excluded); this operation is repeated for each item; an average of all patient items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the patient component of "cross-cultural communication." For the staff component: Each response of "strongly disagree" counts as 0; each response of "disagree" counts as 0.33; each response of "agree" counts as 0.67; each response of "strongly agree" counts as 1.0. Each response of "very poor" counts as 0; each response of "poor" counts as 0.25; each response of "fair" counts as 0.5; each response of "good" counts as 0.75; each response of "very good" counts as 1.0. Each response of "no training" counts as 0; each response

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	Preferred Practice 3: 13 points Preferred Practice 30: 11 points Preferred Practice 32: 11 points Preferred Practice 40: 12 points Preferred Practice 23: 10 points Preferred Practice 37: 11 points Preferred Practice 43: 11 points Preferred Practice 8: 8 points Preferred Practice 10: 5 points TOTAL POINTS 142 As mentioned above, within the scale for each practice, each question has an equal point value, computed as the maximum points for that scale divided by the number of questions that an organization provided a response for in that scale. Item response categories for each question are scored as follows: • No=0 • Yes, within the last 12 months=100 • Yes, within the last 12 months=75 • Yes, within the last 12 months=50 • Yes, within the last 12 months=25 Survey items for which a respondent can select more than one response option are scored as follows: • No=0 • If 1 yes checked=1 • If 2 yes checked=2 • If 3 yes checked=3 Scores are then transformed linearly to 0-100 possible range, resulting in scores of approximately 0, 33.33, 66.66, and 100. The overall score for a survey is the sum of all the points earned for each of the scales included in the survey. The sum of the points earned across all scales in the survey is multiplied by the ratio of 142 maximum points to the sum of available points for each practice. All survey scores will be normalized to 100. All organizations that complete a survey are stratified into quartiles based on their overall points. In order to receive the highest level of recognition, an organization must be in the top quartile of responding	CU5. In the last 12 months, how often did this provider interrupt you when you were talking? (Response: N/S/U/A) CU8. In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Response: N/S/U/A) To calculate the Providers Are Caring and Inspire Trust Composite: STEP1: Calculate the proportion of respondents in each response category for each item in the composite (i.e., the number of respondents who gave the response divided by the total number of respondents who answered that item). Start by calculating for CU16: • The proportion of respondents who answered “never” • The proportion of respondents who answered “sometimes” • The proportion of respondents who answered “usually” • The proportion of respondent who answered “always” Follow this step for CU17, CU18, CU19, and CU20. STEP 2: Calculate the average proportion responding to each category across the questions in the composite. For example, to calculate the composite for those who answered “always,” calculate: (Proportion of respondents who answered “always” to CU16 + Proportion of respondents who answered “always” to CU17 + Proportion of respondents who answered “always” to CU18 + Proportion of respondents who answered “always” to CU19 + Proportion of respondents who answered “always” to CU20)/5 The Communication about Medicines Composite is calculated in the same way, except that – because there are only 3 items in the composite, the denominator in the calculation of the average proportion responding to each category should be divided by 3. Additional detail on the algorithm to calculate these composites is available from the CAHPS® Clinician & Group Surveys Instructions for Patient Experience	of “inadequate training” counts as 0.5; each response of “adequate training” counts as 1.0. responses of "n/a" or "not sure" are excluded. A composite score for each item is calculated by summing the total response score and dividing by the number of valid responses ("n/a" and "not sure" excluded); this operation is repeated for each item; an average of all staff items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the staff component of the domain of "cross-cultural communication." The average of the staff and patient components is obtained, resulting in the measure score for the domain of "cross-cultural communication."

	1919 Cultural Competency Implementation Measure	1904 Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	1894 Cross-cultural communication measure derived from the cross-cultural communication domain of the C-CAT
	organizations in terms of their overall points. Attachment NQF_Survey_FinalReport_23DEC11_tp.pdf	Measures. Instructions for analyzing composite measures in SAS are available in the CAHPS Clinician & Group Surveys and Instructions, Instructions for Analyzing Data. Both are available at: https://www.cahps.ahrq.gov/Surveys-Guidance/CG/Get-CG-Surveys-and-Instructions.aspx. URL https://www.cahps.ahrq.gov/Surveys-Guidance/CG/Get-Surveys-and-Instructions.aspx	
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:	5.1 Identified measures: 0005 : CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: Not applicable.	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:
SC Evaluation			

Health Literacy

	1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	1898 Health literacy measure derived from the health literacy domain of the C-CAT
Steward	Agency for Healthcare Research and Quality	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
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	0-100 measure of health literacy related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit

	1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	1898 Health literacy measure derived from the health literacy domain of the C-CAT
	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)	
Type	Patient Engagement/Experience	Patient Engagement/Experience
Data Source	Patient Reported Data/Survey CAHPS Item Set for Addressing Health Literacy Attachment CAHPS Item Set to Address Health Literacy 1-31-12.docx	Healthcare Provider Survey Communication Climate Assessment Toolkit (C-CAT) survey instruments (staff and patient). Available at: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? URL http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page? Attachment health literacy data library.xls
Level	Clinician : Group/Practice, Clinician : Individual	Facility
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
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)	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.
Numerator Details	Time Window: Last 12 months. Top Box Method: Calculate the number of responses in the most positive response category for each item. Below each item is listed with the most positive response for the item in parentheses. Note that for HL1, HL2, HL3, HL5, HL6, and HL17 the most positive response is "Never." Specific instructions for how reverse coding can be done in SAS can be found in "Instructions for Analyzing CAHPS Data" (available at: https://www.cahps.ahrq.gov/Surveys-Guidance/Dental/~/media/Files/SurveyDocuments/Dental/Prep_Analyze/2015_instructions_for_analyzing_data.pdf) in the section called "Data Set Specification." HL1 In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English? (Never) HL2 In the last 12 months, how often did this provider use medical words you did not understand? (Never) HL3 In the last 12 months, how often did this provider talk too fast when talking with you? (Always)	Time Window: Open data collection period -- ideally all C-CAT data are collected in a discreet data collection period ranging from 1-4 weeks. However, in order to achieve sufficient data sites with smaller patient populations, or those looking to collect data from a specific sub-group, may require a longer data-collection period. The measure result is obtained by calculating a 0-100 score for both the patient and staff component of the measure. Item language is adjusted based on whether site is a hospital or clinic. Patient survey items: p2 (pp2): Could you find your way around the hospital (clinic)? p3 (pp3): Could you understand the hospital (clinic)'s signs and maps? p6 (pp6): Was it easy to ask questions at the hospital (clinic)? p7 (pp7): Were the hospital (clinic)'s forms easy for you to fill out? p8 (pp8): Did hospital (clinic) staff offer to help you fill out the forms? p9 (pp9): Did you understand the hospital (clinic)'s informed consent forms? p13 (pp13): Were the educational materials easy to understand? p16 (pp16): Did doctors explain things in a way you could understand?

	1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	1898 Health literacy measure derived from the health literacy domain of the C-CAT
	HL4 In the last 12 months, how often did this provider use pictures, drawings, models, or videos to explain things to you? (Always) HL5 In the last 12 months, how often did this provider ignore what you told him or her? (Never) HL6 In the last 12 months, how often did this provider interrupt you when you were talking? (Never) HL7 In the last 12 months, how often did this provider show interest in your questions and concerns? (Always) HL8 In the last 12 months, how often did this provider answer all your questions to your satisfaction? (Always) HL9 In the last 12 months, how often did this provider give you all the information you wanted about your health? (Always) HL10 In the last 12 months, how often did this provider encourage you to talk about all your health questions or concerns? (Always) HL11 In the last 12 months, did you see this provider for a specific illness or for any health condition? [screener for HL 12-17] (NA) HL12 In the last 12 months, did this provider give you instructions about what to do to take care of this illness or health condition (Yes) HL13 In the last 12 months, how often were these instructions easy to understand? (Always) HL14 In the last 12 months, how often did this provider ask you to describe how you were going to follow these instructions? (Always) HL15 Sometimes providers give instructions that are hard to follow. In the last 12 months, how often did this provider ask you whether you would have any problems doing what you need to do to take care of this illness or health condition? (Always) HL16 In the last 12 months, how often did this provider explain what to do if this illness or health condition got worse or came back? (Always) HL17 In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Never) HL18 In the last 12 months, did this provider prescribe any new medicines or change how much medicine you should take? [screener for HL19-25] (NA) HL19 In the last 12 months, did this provider give instructions about how to take your medicines? (Yes) HL20 In the last 12 months, how often were these instructions about how to take you medicines easy to understand? (Always) HL21 In the last 12 months, did this provider explain the possible side effects of your medicines? (Yes) HL22 In the last 12 months, how often were these explanations was easy to understand? (Always) HL23 In the last 12 months, other than a prescription, did this provider give you written	p17 (pp17): Did doctors ask you to repeat their instructions? p21 (pp21): Did doctors ask if you had any questions? p23 (pp23): Did you know your main health problem? p24 (pp24): Did you understand your doctor's instructions? p25 (pp25): Did you know how to take your medicine? p27 (pp27): Did you understand what hospital (clinic) staff told you over the phone? p29 (pp29): Do you feel welcome at the hospital (clinic)? Staff survey items: s1: Senior leaders have taken steps to create a more welcoming environment for patients. s6: My direct supervisors have intervened if staff were not respectful towards patients. s16: Hospital (clinic) staff members have communicated well with patients over the phone. s19: Hospital (clinic) staff members have needed more time to communicate well with patients. s39: During the last 6 months, how often did relevant hospital (clinic) staff ask patients if they would like help filling out hospital forms? s42: Overall, how would you rate the understandability of the hospital (clinic)'s patient education materials? s43: Overall, how would you rate the signs and maps at the hospital (clinic)? s44: Overall, how would you rate the hospital (clinic)'s informed consent forms? s48: Overall, how would you rate the hospital (clinic)'s efforts to help patients access community resources (e.g., assistance with medications, nutrition, insurance, legal aid, etc.)? s52: Have you ever received specific and adequate training on communication policies at the hospital (clinic)? s53: Have you ever received specific and adequate training on the impact of miscommunication on patient safety? s54: Have you ever received specific and adequate training on the importance of communicating with patients in plain language instead of using technical terms? s55: Have you ever received specific and adequate training on ways to check whether patients understand instructions (such as the teach-back or the "show-me" methods)? See field 2a1.20 for measure score calculation logic.

	1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	1898 Health literacy measure derived from the health literacy domain of the C-CAT
	information or write down information about how to take your medicines? (Yes) HL24 In the last 12 months, how often was the written information you were given easy to understand? (Always) HL25 In the last 12 months, how often did this provider suggest ways to help you remember to take your medicines? (Always) Core 21 In the last 12 months, did this provider order a blood test, x-ray, or other test for you? [screener for Core 22] (NA) Core 22 In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?(NA) [screener for HL26] HL26 In the last 12 months, how often were the results of your blood test, x-ray, or other test easy to understand? (Always) HL27 In the last 12 months, did you sign any forms at this provider's office [screener for HL28] (NA) HL28 In the last 12 months, how often did someone explain the purpose of a form before you signed it? (Always) HL29 In the last 12 months, did you fill out any forms at this provider's office? [screener for HL30-31] (NA) HL30 In the last 12 months, how often were you offered help to fill out a form at this provider's office? (Always) HL31 In the last 12 months, how often were the forms from this provider's office easy to fill out? (Always)	
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.	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.
Denominator Details	Time Window: Last 12 months. The denominator is the total number of respondents who selected a response option to a particular item. Respondents may have not answered an item because of a screener that skipped them over that item, or because they chose to skip that question.	Time Window: A brief, discreet data-collection period is preferred. A data-collection period of between 1-4 weeks is usually sufficient to collect needed data. Staff respondents should include all staff categories, including both clinical and non-clinical staff as well as those in roles such as building/environmental services, food services, etc. A minimum of 50 staff responses in a variety of staff categories is required to calculate the measure score. Staff surveys are made available in English and Spanish by default, with additional language available upon request. Patient respondents include all patients, with a pediatric version made available for families of minor patients. During field testing, patient surveys were available in 5 languages: English, Spanish, Chinese, Polish and Vietnamese. Currently, English and Spanish language surveys are made available by default with additional languages available upon request (languages determined by organization using the C-CAT). During field testing of the instruments, surveys were available on paper or online and

	1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	1898 Health literacy measure derived from the health literacy domain of the C-CAT
		during phase 1 patient surveys were also available via automated voice response systems. After very few patients replied using the voice automated system, the system was retired from use.
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.	Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.
Exclusion Details	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.	Based on response to the first item on the staff survey ("Does your job involve direct contact with patients? yes/no"), staff respondents who do not have direct contact with patients are excluded from items that relate to direct contact with patients.
Risk Adjustment	No risk adjustment or risk stratification not applicable.	No risk adjustment or risk stratification N/A
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)	N/A
Type Score	Non-weighted score/composite/scale better quality = higher score	Non-weighted score/composite/scale better quality = higher score
Algorithm	Composites can be calculated for an individual provider (e.g., a doctor), or for a practice or clinic. The Communication to Improve Health Literacy Composite consists of 5 items: HL9. In the last 12 months, how often did this provider give you all the information you wanted about your health? (Response: Never/Sometimes/Usually/Always) HL10. In the last 12 months, how often did this provider encourage you to talk about all your health problems or concerns? (Response: N/S/U/A) HL14. In the last 12 months, how often did this doctor ask you to describe how you were going to follow these instructions? (Response: N/S/U/A) HL20. In the last 12 months, how often were these instructions about how to take you medicines easy to understand? (Response: N/S/U/A) HL26. In the last 12 months, how often were the results of your blood test, x-ray or other test easy to understand? (Response: N/S/U/A) The Communication about Medicines Composite consists of 3 items: HL22. In the last 12 months, how often were these explanations [of possible side effects of your medicines] easy to understand? (Response: N/S/U/A) HL24. In the last 12 months, how often was the written information you were given easy to understand? (Response: N/S/U/A) HL25. In the last 12 months, how often did this provider suggest ways to help you remember to take your medicines? (Response: N/S/U/A)	The measure score is an average of the patient and staff components. Calculation of patient component of measure score: each response of "never" counts as 0; each response of "sometimes" counts as 0.5; each response of "always" counts as 1.0; responses of "not sure" are excluded. A composite score for each item is calculated by summing the total response scores and dividing by the number of valid responses ("not sure" excluded); this operation is repeated for each item; an average of all patient items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the patient component of "health literacy." For the staff component: Each response of "never" counts as 0; each response of "rarely" counts as 0.25; each response of "sometimes" counts as 0.5; each response of "often" counts as 0.75; each response of "always" counts as 1.0. Each response of "very poor" counts as 0; each response of "poor" counts as 0.25; each response of "fair" counts as 0.5; each response of "good" counts as 0.75; each response of "very good" counts as 1.0. Each response of "no training" counts as 0; each response of "inadequate training" counts as 0.5; each response of "adequate training" counts as 1.0. For items s1, s6, s16, and s39 responses of "strongly disagree" counts as 0; each response of "disagree" counts as 0.33; each response of "agree" counts as 0.67; each response of "strongly agree" counts as 1.0; item s19 is reverse-coded, so that each response of "strongly disagree counts as 1.0, each

	1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	1898 Health literacy measure derived from the health literacy domain of the C-CAT
	To calculate the Communication to Improve Health Literacy Composite: STEP1: Calculate the proportion of respondents in each response category for each item in the composite (i.e., the number of respondents who gave the response divided by the total number of respondents who answered that item). Start by calculating for HL9: • The proportion of respondents who answered "never" • The proportion of respondents who answered "sometimes" • The proportion of respondents who answered "usually" • The proportion of respondent who answered "always" Follow this step for HL10, HL14, HL20, and HL26. STEP 2: Calculate the average proportion responding to each category across the questions in the composite. For example, to calculate the composite for those who answered "always," calculate: (Proportion of respondents who answered "always" to HL9 + Proportion of respondents who answered "always" to HL10 + Proportion of respondents who answered "always" to HL14 + Proportion of respondents who answered "always" to HL20 + Proportion of respondents who answered "always" to HL26)/5 The Communication about Medicines Composite is calculated in the same way, except that – because there are only 3 items in the composite, the denominator in the calculation of the average proportion responding to each category should be divided by 3. Additional detail on the algorithm to calculate these composites is available from the CAHPS® Clinician & Group Surveys Instructions for Patient Experience Measures. Instructions for analyzing composite measures in SAS are available in the CAHPS Clinician & Group Surveys and Instructions, Instructions for Analyzing Data. Both are available at: https://www.cahps.ahrq.gov/Surveys-Guidance/CG/Get-CG-Surveys-and-Instructions.aspx. URL https://www.cahps.ahrq.gov/Surveys-Guidance/CG/Get-Surveys-and-Instructions.aspx	response of "disagree" counts as 0.67, each response of "agree" counts as 0.33, and each response of "strongly agree" counts as 1.0. responses of "n/a" or "not sure" are excluded. A composite score for each item is calculated by summing the total response score and dividing by the number of valid responses ("n/a" and "not sure" excluded); this operation is repeated for each item; an average of all staff items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the staff component of the domain of "health literacy." The average of the staff and patient components is obtained, resulting in the measure score for the domain of "health literacy."
Submission items	5.1 Identified measures: 0005 : CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: not applicable.	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:
SC Evaluation		

NATIONAL QUALITY FORUM

PROTOCOL FOR SELECTING DISPARITIES-SENSITIVE MEASURES

The Steering Committee suggested that the entire NQF portfolio of measures be reviewed and a subset of disparities-sensitive measures identified for their further review; the following protocol was used after the Committee's review and approval:

1. **<u>First-tier of the Disparities-sensitive Criteria</u>**
   The disparities-sensitive selection criteria (prevalence, impact of condition, impact of the quality process, quality gap, and ease and feasibility of improving the quality process) will serve as a starting point with emphasis placed on prevalence, quality gap and impact to identify measures.
   a. <u>Prevalence</u> - how prevalent the condition is among the minority population? The following conditions are identified by the Office of Minority Health as large contributors of health disparities. The NQF portfolio will first be reviewed for performance measures related to the following conditions: **Cancer, Diabetes, Heart Disease (including Hypertension), HIV/AIDS, Immunizations, Infant Mortality, and Stroke, Tobacco use, Oral care.** These measures will be given 3 points. Measures that fall in **cross-cutting areas** (e.g., patient safety, care coordination, functional status, palliative care, pain management or *any* child health/peds) also will be scored 3 points. Measures that fall into the top 20 of NQF's **"Top 20" priorities,** see table 1 (amended to include substance abuse, Obesity, and ESRD) will be scored 2 points. All other measures will be scored 1 point.
   b. <u>Quality gap</u> – how large the gap in quality *of care* between the disparity population and the group with the highest quality for that measure. Measure submission/evaluation forms will be reviewed and the gap information for that measure will be recorded. After NQF staff assesses the range and nature of gap information available, we will consult with the Steering Committee as to appropriate demarcation of (relatively) large, medium, small gaps and score appropriately based on this schema. (i.e., the gap information will be assessed and distribution shown by percentages, 50%, 30%, etc. – then each group will be assigned a scoring number).
   c. <u>Impact</u> – the influence a condition or topic has financially, publically, and on the community at large. Performance measures addressing the National Quality Strategy priority areas or goals will be given a score of 1 point each AND/OR a demonstrated high impact aspect of healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use (current and/or future), severity of illness, and patient/societal consequences of poor quality) 1 point for any one of these factors.

2. **Second Tier of the Disparities-sensitive selection Criteria**
   Following this initial review, an additional filter will be applied to those measures where performance data is not stratified by race/ethnicity or when a known disparity does not exist. The measures will be reviewed using the following criteria:
   a. Care with a High Degree of Discretion - Many of the disparities described depends on a certain degree of discretion on the part of the clinician. The less there is a standard protocol that must be followed, the easier it is for a clinician to offer a procedure differently based on the patient's socio-demographic characteristics (whether or not this is consciously factored into the decision). NQF staff can review the measure submission forms and identify those measures that specifically cite a clinical guideline as part of the evidence, scoring those that do as having 2 points and those without as 0.
   b. Communication-Sensitive Services - Disparities are more likely to occur when there are challenges to communication across language and cultures. As an indicator of communication-sensitive services, performance measures will be tagged for the Committee's review as disparities-sensitive when they match one of the following NQF-endorsed framework domains; scoring those that do as having 2 points and those that do not as 0.
      i. Cultural Competency Framework Domain: Patient-Provider Communication and the corresponding sub-domains and/or preferred practices.
      ii. Care Coordination Framework Domain: Communication and the corresponding sub-domains and/or preferred practices
   c. Social Determinant-Dependent Measures - Disparities often are seen in areas that relate to behavioral aspects of health, including patient self-management (e.g., diet, exercise, and medication adherence for diabetes or congestive heart failure management). As an indicator of social determinant-dependent measures, performance measures should be matched to social or behavioral aspects of health. Measures in the NQF portfolio that are within the direct "control sphere" of either healthcare delivery or public health will be given a score of 3 points; measures that address behavioral aspects of health will be given a score of 2 points; measures that address environmental aspects will be given 1 point and measures that meet other social determinant indicators will be given a score of 0.

3. **Tagging of All Measures as Screening Proceeds**

All measures will be tagged as belonging to a specific category as outlined in the commissioned paper:

a. Practitioner Performance
b. Consumer Surveys that measure patient experience
c. Hospital, Ambulatory care, home health nursing home
d. Ambulatory care sensitive conditions and management
e. Cultural Competency
f. Patient-Centered

All measures will be further identified as system-based or provider-based, then cross-cutting or the potential to influence multiple measures. In addition, the measure type (structure, process, and outcome) will be indicated.

Table 1. Prioritized List of 20 High-Impact Medicare Conditions

Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke / Transient Ischemic Attack
6. Alzheimer’s
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/ Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis / Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

NATIONAL QUALITY FORUM

NQF is actively reviewing the portfolio of endorsed measures to identify those that could be considered to be disparities-sensitive according the protocol. Table 2 provides an example of a measure that has been reviewed against the protocol and the rationales.

Table 2.

NQF #18: Controlling High Blood Pressure. The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. (Steward: National Committee for Quality Assurance)

Protocol indicator	Measure rationales	Scoring
Prevalence	Measure meets one of the conditions under prevalence – Heart Disease	3 points
Quality Gap[1]	a quality gap of 3.7% was provided in measure form	To be determined
Impact	Measure can be mapped to at least one of the NPP priorities or goals	1 point
Clinical Guideline	Measure meets a clinical guideline and citation for guideline is provided in measure form	2 points
Communication-sensitive services	Measure do not map to the NQF-endorsed preferred practices addressing communication services	0 points
Social-determinants	Measure determined to be in the direct "control sphere" of the healthcare delivery or public health; based on measure description and specifications.	3 points
Category	Measure category determined – Practitioner performance and provider-based	Not applicable as pertains to point assignments; for categorization purposes (N/A)
Measure Type	Process Measure	N/A
Cross-Cutting	Measure is not cross-cutting	N/A
Linked to the NQF Ambulatory care project	Measure originally endorsed under the NQF Ambulatory Care Disparities Sensitive Measure Set	N/A

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[1] The criterion "quality gap" is still being assessed to determine the range of values (gap percentages) among the portfolio of endorsed measures, after which an applicable scoring for values (or ranges of values) shall be derived.