



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 1919

Corresponding Measures:

De.2. Measure Title: Cultural Competency Implementation Measure

Co.1.1. Measure Steward: RAND Corporation

De.3. Brief Description of Measure: The Cultural Competence Implementation Measure is an organizational survey designed to assist healthcare organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed® cultural competency practices prioritized for the survey. The target audience for this survey includes healthcare organizations across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations. Information from the survey can be used for quality improvement, provide information that can help health care organizations establish benchmarks and assess how they compare in relation to peer organizations, and for public reporting.

1b.1. Developer Rationale: Organizations that use the Cultural Competency Implementation Measure can use the results to evaluate their organization's adherence to the 12 NQF-endorsed cultural competency practices covered in the survey, to identify areas for quality improvement within an organization (particularly related to making improvements in patients' experience of care), to provide feedback to providers, and to inform consumers. Organization's that field the survey measure can report scores for each of the 12 cultural competency preferred practices covered in the survey, as well as a total survey score. Health care organizations using this measure can use their practice (or subdomain) level score as well as their total survey score for benchmarking and reporting at the group or practice site level. For example, a health system may report their scores to compare adherence adherence to the NQF-endorsed cultural competency practices covered in the survey across provider groups or a provider group may compare performance across practice sites. In terms of quality improvement, the survey measure can generate data that organizations can use to improve specific areas related to specific NQF-endorsed cultural competency practices. Organizations can identify their strengths and weaknesses by preferred practice and once they have identified opportunities for improvement and embarked on quality improvement activities ,the organization can field the survey measure again to evaluate the success of improvement activities.

S.4. 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.

S.7. 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.

S.10. Denominator Exclusions: Not applicable. The current version of the survey is designed to work across health care settings and different types of health care organization in terms of population served, size, and location.

De.1. Measure Type: Structure

S.23. Data Source: Instrument-Based Data

S.26. Level of Analysis: Facility, Health Plan, Integrated Delivery System

IF Endorsement Maintenance – Original Endorsement Date: Aug 09, 2012 **Most Recent Endorsement Date:** Aug 09, 2012

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form
[1919_Evidence_MSF5.0_Data.doc](#)

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

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

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

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

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

low-health literacy, and low-income populations.

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

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

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

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

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

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

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

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

Weech-Maldonado R, Morales LS, Elliott M, Spritzer K, Marshall G, Hays RD. Race/ethnicity, language, and patients' assessments of care in Medicaid managed care. *Health Serv Res*. Jun 2003;38(3):789-808.

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

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

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

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

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

Saha S, Arbelaez JJ, Cooper LA. Patient-physician relationships and racial disparities in the quality of health care. Am J Public Health. Oct 2003;93(10).

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

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

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

Hunt KA, Gaba A, Lavizzo-Mourey R. Racial and ethnic disparities and perceptions of health care: does health plan type matter? Health Serv Res. Apr 2005;40(2):551-576.

Schnittker J. Social Distance in the Clinical Encounter: Interactional and Sociodemographic Foundations for Mistrust in Physicians. Social Psychology Quarterly. 2004;67(3):217-235.

Meredith LS, Siu AL. Variation and quality of self-report health data. Asians and Pacific Islanders compared with other ethnic groups. Med Care. Nov 1995;33(11):1120-1131.

LaVeist TA, Nickerson KJ, Bowie JV. Attitudes about racism, medical mistrust, and satisfaction with care among African American and white cardiac patients. Med Care Res Rev. 2000;57 Suppl 1:146-161.

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

U.S. Census Bureau, 2008

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

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

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

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

As mentioned above, numerous studies have looked at disparities in access to healthcare and health outcomes by population group.

Perhaps the most compelling summary of the data on disparities by population group was presented in a 2003 report by the IOM (Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare). This report presents a summary of the evidence and finds that disparities are consistent across a range of illnesses and healthcare services.

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

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

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

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

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

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

Franks AL, Mays DS, Wegner NK, Blunt SB, Eaker ED. Racial differences in the use of invasive coronary procedures after acute myocardial infarction in Medicare beneficiaries. Ethnicity and Disease. Summer 1993;3(3):213-220.

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

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

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

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

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

Prislin R, Dyer JA, Blakely CH, Johnson CD. Immunization status and sociodemographic characteristics: the mediating role of beliefs, attitudes, and perceived control. American Journal of Public Health. 1998;88(12):1821-1826.

King WD, Wong MD, Shapiro MF, Landon BE, Cunningham WE. Does racial concordance between HIV-positive patients and their physicians affect the time to receipt of protease inhibitors? J Gen Intern Med. Nov 2004;19(11):1146-1153.

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

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

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

Weech-Maldonado R, Morales LS, Elliott M, Spritzer K, Marshall G, Hays RD. Race/ethnicity, language, and patients' assessments of care in Medicaid managed care. Health Serv Res. Jun 2003;38(3):789-808.

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

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. 2010 National Healthcare Disparities Report. AHRQ Publication No. 11-0005. Agency for Healthcare Research and Quality: Rockville, MD, March 2011.

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

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

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

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

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

No doubt the causes of these health disparities are the result of multiple factors including bias (conscious or unconscious) on the part of the providers, differences in patients' expectations, miscommunication caused by cultural differences, and organizational factors that impact the quality of patient-provider interactions. However, there is also growing evidence that a major contributor to healthcare disparities is a lack of culturally competent care. Cultural competence can be defined as the ongoing capacity of healthcare systems, organizations, and professionals to provide diverse populations high quality care that is safe, patient and family centered, evidence-based, and equitable. To be culturally competent, health care providers have to employ various interpersonal

and organizational strategies to overcome or at the very least reduce the barriers to access, communication, and understanding that stem from racial, ethnic, cultural, and linguistic differences. Providing culturally appropriate care has the potential to reduce disparities and improve outcomes while at the same time improving patient satisfaction.

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

1c.4. Citations for data demonstrating high priority provided in 1a.3

1. Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: National Academies Press; 2002.
2. IOM, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC: National Academy Press; 2001.
3. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. 2010 National Healthcare Disparities Report. AHRQ Publication No. 11-0005. Agency for Healthcare Research and Quality: Rockville, MD, March 2011.
4. Collins KS, Hughes DL, Doty MM, Ives BL, Edwards JN, Tenney K. *Diverse communities, common concerns: Assessing health care quality for minority Americans*. New York: The Commonwealth Fund; 2002.
5. Wilson-Stronks A, Galvez E, *Hospitals, Language, and Culture: A Snapshot of the Nation*, Oakbrook Terrace, IL: The Joint Commission; 2008, pp. 60-64. Available at www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf. Last accessed February 2009.
6. Gornick ME, Disparities in Medicare services: potential causes, plausible explanations and recommendations, *Health Care Financ Rev*, 2000;21(4):23-43.
7. Coleman-Miller B, A physician's perspective on minority health, *Health Care Financ Rev*, 2000;21(4):45-56.
8. Williams DR, Rucker TD, Understanding and addressing racial disparities in health care, *Health Care Financ Rev*, 2000;21(4):75-90.
9. C. M. Ashton, P. Haidet, D. A. Paterniti et al., "Racial and Ethnic Disparities in the Use of Health Services: Bias, Preferences, or Poor Communication?" *Journal of General Internal Medicine*, 2003 18(2):146–152.
10. K. Fiscella, P. Franks, M. P. Doescher et al., "Disparities in Health Care by Race, Ethnicity, and Language Among the Insured: Findings from a National Sample," *Medical Care*, 2002 40(1):52–59.
11. P. Franks, K. Fiscella, and S. Meldrum, "Racial Disparities in the Content of Primary Care Office Visits," *Journal of General Internal Medicine*, 2005 20:599–603;

12. Q. Ngo-Metzger, A. T. R. Legedza, and R. S. Phillips, 2004; S. Saha, J. J. Arbelaez, and L.A. Cooper, "Patient-Physician Relationships and Racial Disparities in the Quality of Health Care," *American Journal of Public Health*, 2003 93(10):1713-1719.
13. Einbinder LC, Schulman KA, The effect of race on the referral process for invasive cardiac procedures, *Med Care Res Rev*, 2000;57(Suppl 1):162-180.
14. Mead H, Regenstein M, Lara A, The heart of the matter: the relationship between communities, cardiovascular services and racial and ethnic gaps in care, *Manage Care Interface*, 2007;20(8):22-28.
15. Blackhall LJ, Murphy ST, Frank G, et al., Ethnicity and attitudes toward patient autonomy, *JAMA*, 1995;274(10):820-825.
16. Piette JD, Schillinger D, Potter MB, et al., Dimensions of patient-provider communication and diabetes self-care in an ethnically diverse population, *J Gen Intern Med*, 2003;18(8):624-633.
17. Jacobs EA, Lauderdale DS, Meltzer D, et al., Impact of interpreter services on delivery of healthcare to limited-English proficient patients, *J Gen Intern Med*, 2001;16(7):468-474.
18. Tocher TM, Larson EB, Do physicians spend more time with non-English-speaking patients? *J Gen Intern Med*, 1999;14(5):303-309.
19. Q. Ngo-Metzger, M. P. Massagli, B. Clarridge et al., "Health Care Experiences of Limited-English Proficient Chinese and Vietnamese Americans," *Journal of General Internal Medicine*, 2003 18(S):184.
20. B. Smedley, A. Stith, A. Nelson, 2002; S. A. Fox and J. A. Stein, "The Effect of Physician-Patient Communication on Mammography Utilization by Different Ethnic Groups," *Medical Care*, 1991 29(11):1065-1082.
21. M. Stewart, 1995; S. H. Kaplan, S. Greenfield, J. E. Ware, Jr., "Assessing the Effects of Physician-Patient Interactions on the Outcomes of Chronic Disease," *Medical Care*, 1989 27(3 Suppl):S110-127.
22. B. Smedley, A. Stith, A. Nelson, eds., 2002; M. van Ryn and J. Burke, "The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients," *Social Science and Medicine*, 2000 50(6):813-828.
24. R. A. Bell, R. L. Kravitz, D. Thom et al., "Unmet Expectations for Care and the Patient-Physician Relationship," *Journal of General Internal Medicine*, 2002 17(11):817-824.
25. J. L. Murray-Garcia, J. V. Selby, J. Schmittdiel et al., 2000; K. A. Hunt, A. Gaba, R. Lavizzo-Mourey, 2005; J. Schnittker, "Social Distance in the Clinical Encounter: Interactional and Sociodemographic Foundations for Mistrust in Physicians," *Social Psychology Quarterly*, 2004 67(3):217-235.
26. M. D. Wong, S. M. Asch, R. M. Andersen et al., "Racial and Ethnic Differences in Patients' Preferences for Initial Care by Specialists," *American Journal of Medicine*, 2004 116(9):613-620.
27. J. Z. Ayanian, P. D. Cleary, J. S. Weissman et al., "The Effect of Patients' Preferences on Racial Differences in Access to Renal Transplantation," *New England Journal of Medicine*, 1999 341(22):1661-1669.
28. W. D. King, M. D. Wong, M. F. Shapiro et al., "Does Racial Concordance Between HIVPositive Patients and Their Physicians Affect the Time to Receipt of Protease Inhibitors?" *Journal of General Internal Medicine*, 2004 19(11):1146-1153.
29. J. Z. Ayanian, I. S. Udvarhelyi, C. A. Gatsonis et al., "Racial Differences in the Revascularization Procedures After Angiography," *Journal of the American Medical Association*, 1993:2642-2646.
30. A. L. Franks, D. S. Mays, N. K. Wegner et al., "Racial Differences in the Use of Invasive Coronary Procedures After Acute Myocardial Infarction in Medicare Beneficiaries," *Ethnicity and Disease*, Summer 1993 3(3):213-220.

31. W. H. Giles, R. F. Anda, M. L. Casper et al., "Race and Sex Differences in Rates of Invasive Cardiac Procedures in U.S. Hospitals," *Archives of Internal Medicine*, 1995 155(3):318–324.
32. J. Whittle, J. Coniglaro, C. B. Good et al., "Racial Differences in the Use of Invasive Cardiovascular Procedures in the Department of Veterans Affairs Medical System," *New England Journal of Medicine*. 1993 329(9):621–627.
33. T. E. King and P. Brunetta, "Racial Disparity in Rates of Surgery for Lung Cancer," *New England Journal of Medicine*, 1999 341(16):1231–1233.
34. Flores G, Language barriers to health care in the United States: perspective, *N Engl J Med*, 2006;355(3):229-231.
35. Betancourt JR, Green AR, Carrillo JE, et al., Cultural competence and health care disparities: key perspectives and trends, *Health Aff*, 2005;24(2):499-505.
36. Betancourt JR, Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care, New York: The Commonwealth Fund; 2006. Available at www.commonwealthfund.org/usr_doc/Betancourt_improvingqualityachievingequity_961.pdf?section=4039. Last accessed February 2009. 227.
37. 9. Paasche-Orlow M, The ethics of cultural competency, *Acad Med*, 2004;79(4):347-350.
38. Taylor SL, Lurie N, The role of culturally competent communication in reducing ethnic and racial healthcare disparities, *Am J Manag Care*, 2004;Spec No:SP1-4.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific (check all the areas that apply):
[Care Coordination](#), [Disparities Sensitive](#), [Person-and Family-Centered Care](#)

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to

general information.)

<https://www.randsurvey.org/ccis/>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

URL Attachment:

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

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.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

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, within the last 12 months; yes, within the last 13-24 months; yes, within 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.

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

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).

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

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

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

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.

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

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

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

N/A

S.12. Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*

N/A

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*

N/A

S.15. Detailed risk model specifications *(must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)*

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications *(if not provided in excel or csv file at S.2b)*

S.16. Type of score:

If other:

S.17. Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*

Better quality = Higher score

S.18. Calculation Algorithm/Measure Logic *(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)*

The Cultural Competency Implementation Measure is specifically designed to collect information on an organization's progress on 12 of the NQF-endorsed® cultural competency practices. Each practice is assigned an individual weight, which is factored into the overall score. The aim is to rank organizations by quartiles based on their relative progress out of the total number of possible points. The scales associated with each of the preferred cultural competency practices that are covered by the survey are weighted differently for purposes of scoring but equal weighting is used for the survey items that comprise the scale. The maximum number of points for each scale based on the relative impact of the cultural competency practice with which it is associated. Table 3 below provides an overview of the scoring for each of the practices covered by the survey. The maximum number of points for all practices combined is 142.

Table 3

Scoring by Preferred Practice

Practice Name and Number Weighting (pts)

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

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

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

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

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

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

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

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment *(You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*

S.20. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

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

the survey.

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

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

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

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Instrument-Based Data

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

N/A

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

URL

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility, Health Plan, Integrated Delivery System

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Home Care, Inpatient/Hospital, Post Acute/Long Term Care Facility : Rehabilitation, Post-Acute Care

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules,

or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

[1919_MeasureTesting_MS5.0_Data.doc](#)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

[Other](#)

If other: [Data elements are generated by fielding the Cultural Competence implementation Measure](#)

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)

[ALL data elements are in defined fields in a combination of electronic sources](#)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

[The Cultural Competency Implementation Measure is designed to be administered as a web survey with the option of printing out the survey and completing it hardcopy. Upon completing the survey, respondents receive their total survey score as well as their score by practice \(subdomain\). Programming the survey for web administration has the advantage of making the survey easily accessible to respondents from any location, dramatically reduces the cost of implementing the survey, reduces measurement errors significantly given that respondents are forced to answer questions in a specific order, are not allowed to skip or leave survey items blank, and are not allowed to enter response options that are invalid or out of range. In addition, administering the survey over the web eliminates the need for data entry of survey responses and reduces the time required to process the survey data once the survey is completed. To increase response rates, we strongly encourage conducting phone follow-up using via telephone, email, fax, and even regular mail. Feedback received from survey organizations that participated in the field test conducted as part of the](#)

development of the measure would seem to indicate that the survey measure is easy to complete with survey completion times ranging from 15 minutes to 180 minutes (average time to complete the survey was 53 minutes). Although the survey measure was shortened and stream-lined as much as possible based on findings from the development and testing process, the survey measure is still rather lengthy. To reduce or limit the burden to participating organizations, the survey should probably not be fielded more than once per year. Our experience in field testing the survey measure also points to other things that one can do to motivate participation in the survey and reduce the burden on respondents. This includes carefully timing the survey to avoid competing with other organizational surveys, seeking the endorsement and support of the survey from stakeholder groups and member organizations, sending organizations selected to participate in the survey a hardcopy of the survey, guidance documentation, and other supporting documentation so that they don't have to print it out themselves, and allowing participating organizations sufficient time to complete the survey (this is particularly important for large organizations that required the involvement of multiple departments and/or individuals in order to complete the survey). Finally, feedback received from organizations that participated in the field test indicates that a wide range of organizations have a great deal of interest in the survey, not only as a source of information they can use for quality improvement purposes, but also as a source of information for benchmarking performance and comparing themselves to peer organizations.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
Public Reporting	
Quality Improvement (Internal to the specific organization)	

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for

implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

The survey measure is programmed for web survey administration which drastically reduces survey administration error (respondents are unable to leave fields blank or to enter responses other than those available in the survey). However, it is possible that the available survey responses don't accurately capture the responding organization's intended response. The survey allows respondents to enter comments at the end of each section of the survey and then once more at the very end of the survey. Going forward, we will be evaluating the comments provided by respondents as well as any other feedback provided by respondents in order to assess whether there are any issues or problems either with the survey measures as currently worded, or the response scales provided in the survey measure. If necessary, we will revise the survey in the next version to be released. The algorithm for scoring the survey is also programmed as part of the survey so

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications completely harmonized?

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

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [RAND Corporation](#)

Co.2 Point of Contact: [Beverly Weidmer](#), Beverly_Weidmer@rand.org, 310-393-0411-6788

Co.3 Measure Developer if different from Measure Steward: [RAND Corporation](#)

Co.4 Point of Contact: [Beverly Weidmer](#), Beverly_Weidmer@rand.org, 310-393-0411-6788

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

[Paul M. Schyve, MD \(Co-Chair\)](#)

[The Joint Commission](#)

[Oakbrook Terrace, IL](#)

[Kimberlydawn Wisdom, MD, MS \(Co-Chair\)](#)

[Henry Ford Health System](#)

[Detroit, MI](#)

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Centers for Medicare & Medicaid Services
Baltimore, MD

This 17-person Expert Panel convened in 2010 and 2011 (prior to the start of the project to develop the survey measure) to provide expertise and strategic direction for measurement of the NQF-endorsed® preferred practices for cultural competency. The Panel provided input and recommendations for the conceptual development of an implementation survey measure related to the cultural competency practices, strategies for implementing the practices in a range of care settings and from a multi-stakeholder perspective, and recommendations for measure concepts related to the cultural competency practices included in the implementation measure. As part of the survey development process, the survey developer presented the development approach and draft survey measures to the Expert Panel and sought feedback on issues related to content of the survey measure, measure recall period, and scoring approach.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2011

Ad.3 Month and Year of most recent revision: 12, 2011

Ad.4 What is your frequency for review/update of this measure? Annually.

Ad.5 When is the next scheduled review/update for this measure? 02, 2012

Ad.6 Copyright statement: © Copyright 2012 RAND Corporation

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Ad.7 Disclaimers: N/A

Ad.8 Additional Information/Comments: N/A