ENDORSEMENT SUMMARY: Healthcare Disparities and Cultural Competency Measures

AUGUST 2012

Purpose of the Project

Research from the Institute of Medicine shows that racial and ethnic minorities often receive lower quality care than their white counterparts, even after controlling for factors such as insurance coverage, socioeconomic status, and comorbidities.[1] Such disparities are exacerbated by additional factors. Racial and ethnic minorities have poorer health status in general, face more barriers to care, and are more likely to have poor health literacy.

Performance measures that evaluate how and why disparities exist are an essential part of the effort to eliminate health disparities. NQF has previously endorsed disparities-sensitive measures for ambulatory care, in addition to establishing criteria for evaluating disparities-sensitive measures. In February 2011, NQF began a new project – funded by the Robert Wood Johnson Foundation – that sought to expand on its earlier work and establish a more detailed picture of how to approach measurement of healthcare disparities across settings and populations.

The project began with a commissioned paper that outlined methodological concerns with measuring disparities. These include data collection, the implications of risk adjustment and stratification, and the unintended consequences of public reporting. The paper also advised revising the original disparities-sensitive evaluation criteria, and identifying broader sets of disparities-sensitive measures within the NQF portfolio. This paper helped guide NQF efforts to endorse a set of related performance measures.

What Was Endorsed

Summary of Healthcare Disparities and Cultural Competency Project

Measure submitted for consideration	16
Measures recommended for endorsement	12 (0 maintenance)
Measures not recommended for endorsement	4

Under the healthcare disparities and cultural competency project, NQF endorsed 12 measures suitable for accountability and quality improvement. All 12 measures were new.

Measure stewards included a range of healthcare stakeholders, including the American Medical Association; the Agency for Healthcare Research and Quality; RAND Corporation; and the Department of Health Policy at The George Washington University. A full list of measures is available at the end of this report.

The Need these Measures Fill

This new set of measures will significantly advance quality improvement efforts to eliminate disparities across the healthcare community. Several measures use surveys from the American Medical Association's Communication Climate Assessment Toolkit, designed to help improve patient-provider interaction. In addition, the Agency for Healthcare Research and Quality measures

NATIONAL QUALITY FORUM

use the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Item Set for Addressing Health Literacy to evaluate provider communications, disease self-management, and communication about medicines, test results, and forms. Finally, RAND's cultural competency implementation measure is designed to help healthcare organizations identify how well they provide culturally competent care, serve the needs of diverse populations, and adhere to 12 out of 45 NQF-endorsed cultural competency practices. All of these measures will be helpful to providers working to improve care for all patients.

Potential Use

These measures are designed for use by a range of clinical settings and providers, physician offices, ambulatory centers, health plans and hospitals.

Project Perspectives

Eliminating healthcare disparities and improving cultural competency are integral to advancing quality improvement efforts throughout the healthcare system. These new measures are even more significant in that the majority of them evaluate patient experience, an increasingly important concern in quality measurement and improvement. When providers directly engage with patients – whether by holding conversations in a native language, ensuring patients understand medication adherence, or establishing a level of trust throughout treatment – they are better able to deliver high-quality care to vulnerable populations.

Throughout the project, NQF identified several important concepts beyond race, ethnicity, and language that future disparities-related measure development will need to address. These include:

- Leadership and accountability
- Addressing other populations with known disparities, such as gender, low socioeconomic status, and persons with disabilities. 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 (ex. 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

Endorsed Measures

1888: Workforce development measure derived from the workforce development domain of the Communication Climate Assessment Toolkit (CCAT) (American Medical Association)

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

1901: Performance evaluation measure derived from the performance evaluation domain of the Communication Climate Assessment Toolkit (CCAT) (American Medical Association)

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

1905 Leadership commitment measure derived from the leadership commitment domain of the Communication Climate Assessment Toolkit (CCAT) (American Medical Association)

Description: Site score on the measure derived from the domain of "Leadership Commitment" of the Communication Climate Assessment Toolkit (C-CAT), 0-100.

1892: Individual engagement measure derived from the individual engagement domain of CCAT (American Medical Association)

Description: Site score on "Individuals' Engagement" domain of patient-centered communication, per the Communication Climate Assessment Toolkit (C-CAT); 0-100.

1894: Cross-cultural communication measure derived from the cross-cultural communication domain of the CCAT (American Medical Association)

Description: Site score for "cross-cultural communication" domain of Communication Climate Assessment Toolkit (C-CAT), 0-100.

1896: Language services measure derived from the language services domain of CCAT (American Medical Association)

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

1898: Health literacy measure derived from the health literacy domain of CCAT (American Medical Association)

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

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

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)

1904: Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set (AHRQ)

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).

1821: L2: Patients receiving language services supported by qualified language services providers (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.

1824: L1A: Screening for preferred spoken language for health care (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.

1919: Cultural Competency Implementation Measure (RAND)

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.

Endnotes

1. Institute of Medicine (IOM). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press, 2003. Available at http://www.nap.edu/openbook.php?isbn=030908265X. Last accessed August 2012.

NATIONAL
QUALITY FORUM

1030 15TH STREET, NW, SUITE 800
WASHINGTON, DC 20005
WWW.QUALITYFORUM.ORG