

Measuring Improvement in the Patient-Consumer Experience of Health Care: Aligning and Leveraging Measures of Health Literacy, Language Access and Cultural Competence

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Executive Summary

Health literacy, language access and cultural competence are commonly suggested concepts that address the provision of quality care to diverse populations, including those facing persistent health care disparities based on individual characteristics such as race, ethnicity and culture; as well as communication, literacy and language needs. Although health literacy, language access and cultural competence are linked concepts, each has grown out of distinct histories and each has a different focus. This fragmentation has impeded the implementation of relevant measures for quality improvement and accountability, especially given complaints about proliferating quality measures.

The rapid expansion of value-based payment models presents further opportunities and challenges for at-risk populations amid growing recognition that social risk factors play an important role in quality measurement. Because it may take more resources to care for patients with social risk factors—and because it may be more difficult to achieve higher performance on quality of care measures—there are concerns that value-based payments may have unintended consequences for providers who care for such at-risk populations. An integrated framework for addressing health literacy, language access and cultural competence will support greater attention to these concepts in value-based payment arrangements. Hence, the purpose of this paper is to propose a framework for integrating measurement of health literacy, language access and cultural competence that can be used to improve care quality and reduce disparities.

To create this framework, we considered the evidence about the common elements of effective interventions to improve patient understanding and engagement in health care, and identified essential components of a care system for addressing health literacy, language access and cultural competence.

Our review of existing measures found many structure, process and patient experience measures that are relevant to this framework and can be readily implemented through a patient-centered care lens. Yet, challenges remain.

We recommend five strategies for an integrated, patient-centered framework, and offer recommendations to guide broader implementation and evaluation of these critical aspects of care:

- Use structure measures to build capacity and demonstrate capability to serve diverse population needs.
- Develop streamlined tools and new techniques to gather patient experiences.
- Stratify existing quality measures to target improvement and equity.
- Develop packages of measures for vulnerable subpopulations.
- Use independent, specific-focus measures to drill down for quality improvement purposes, and to support performance on integrated measures used for public reporting.

More work will be needed to apply this integrated, patient-centered framework to the adaptation and development of measures that can be used for quality improvement and accountability. Measures and methods need to be updated to address gaps and inconsistencies, and this will require a multi-stakeholder process that includes patients, representatives of different types of health care organizations and payers, to fully vet and develop these ideas.

1.0 INTRODUCTION

The rapid expansion of value-based payment models presents challenges and opportunities for at-risk populations. Quality measurement is critical to improving health care and outcomes, and the results are used in diverse ways. Health plans and providers use quality measures to identify care gaps and guide quality improvement (QI). Consumers use quality measures to select plans and providers. Purchasers are increasingly using value-based payment models - which consider both the quality and costs of care - to selectively reward performance. Because it may take more resources to care for patients with social risk factors—and because it may be more difficult to achieve higher performance on quality of care measures—there are concerns that value-based payments may have unintended consequences for providers who care for such at-risk populations.^{1,2,3,4} Strategies for addressing these issues include measuring health equity, setting high standards for all populations and considering incentives for organizations that achieve or improve performance for at-risk populations.² These may include strategies to address peoples' health literacy, language access and cultural needs, all of which may disproportionately affect populations facing multiple social risk factors.

While the concepts of health literacy, language access and cultural competence are essential aspects of high-quality care for diverse and at-risk populations,^{5,6} these topics are rarely included in national quality measurement programs. In an environment where there is a desire for a limited number of measures,^{7,8} measures for special populations receive less attention. In a literature review conducted previously, we found only four process measures used in national programs, and none address clinical care. Rather, they focus on health plan characteristics or services (e.g., two National Committee for Quality Assurance diversity of membership measures and two Centers for Medicare and Medicaid Services measures assessing availability of language help for members using health plan customer service). Of the patient experience measures we found, only a hospital survey includes items specifically addressing health literacy, and none include items for assessing cultural competence and language needs.⁶

¹ Centers for Medicare & Medicaid Services (CMS). (n.d.; a) Value-Based Programs. Retrieved from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html>.

² Joynt, K. E., De Lew, N., Sheingold, S. H., Conway, P. H., Goodrich, K., & Epstein, A. M. (2017). Should Medicare Value-Based Purchasing Take Social Risk into Account?. *New England Journal Of Medicine*, 376(6), 510-513.

³ National Academies of Sciences, Engineering, and Medicine. (2017). Accounting for Social Risk Factors in Medicare Payment. Washington, DC: The National Academies Press. doi:<https://doi.org/10.17226/23635>.

⁴ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE). (2016, December). *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*. Retrieved from <https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf>

⁵ National Academies of Sciences, Engineering, and Medicine. (2016). *Integrating Health Literacy, Cultural Competence, and Language Access Services: Workshop Summary*. Washington, DC: The National Academies Press.

⁶ National Committee for Quality Assurance (NCQA). (March 2015). Deliverable 2.1: Culturally and Linguistically Appropriate Services (CLAS) & Disparities Literature Review. Submitted to the Centers for Medicare & Medicaid Services, March 18, 2015, under contract number: HHSM-500-2014-00442G.

⁷ Institute of Medicine. (2015). *Vital Signs: Core Metrics for Health and Health Care Progress*. Washington, DC: The National Academies Press

⁸ Centers for Medicare & Medicaid Services (CMS). (2016, February 16). Core Measures. Retrieved from <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualitymeasures/coremeasures.html>

The fragmented approach to measurement exists because these concepts have developed from separate theories and stakeholder perspectives. Although health literacy, language access and cultural competence are linked concepts and share commonalities—including overlapping populations, similar implications for care providers or organizations and the primary goal of improving quality of care—each concept has grown out of distinct histories that emphasize different aspects of care, subgoals and patient subgroups that do not always overlap (e.g., health literacy efforts lean toward improving quality for a broad array of patients; language access and cultural competence efforts lean toward improving quality by focusing on racial/ethnic or linguistic minorities or other at-risk populations).^{5,9} These separate histories have resulted in fragmented measurement approaches—with different constituencies advocating their own QI approaches and multiple quality measures—to monitor at-risk populations—that make implementation challenging, especially in an era of complaints about proliferating quality measures and demands for measure alignment across payers and settings.

An integrated approach to measurement that uses “umbrella” measures that address multiple domains of quality, promises to increase the utility of measures and reduce barriers to implementation. Such an approach can help purchasers align around common concepts. To that end, the purpose of this paper is to propose a framework to integrate measurement of health literacy, language access and cultural competence, with the primary goal of using this integrated measurement approach to improve care quality and reduce disparities. The remaining four chapters of this report are organized as follows: Chapter 2 defines and provides evidence for health literacy, language access and cultural competence and related concepts and explores opportunities for alignment among linked concepts. Chapter 3 introduces and describes a proposed framework for integration of measures of these concepts, and provides examples of known effective interventions addressing these concepts. Chapter 4 discusses measurement opportunities and challenges. Chapter 5 recommends next steps for implementing an integrated measurement framework.

2.0 DEFINITIONS AND EVIDENCE FOR CONCEPTS

In this chapter, we provide information on the concepts originally identified by the NASEM committee: health literacy, language access and cultural competence. For each concept, we answer the questions: 1) how is the concept defined?; 2) when was the concept first notably publicized and/or when did it gain wider attention?; 3) what is the scope of the problem?; 4) what are implications for health care?; and 5) what evidence-based interventions improve care and outcomes? While health literacy, cultural competence and language access originally captured concerns for serving a diverse population, more recent work has expanded these concepts. The enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) has broadened the focus from language access to address communication holistically and from cultural competence to include a broader concept of culture and patient-centeredness. Definitions of these concepts are provided in Exhibit 1. A summary of evidence-based interventions is provided in Exhibit 2.

⁹ Beach, M. C., Saha, S., Cooper, L. A. (2006, October). *The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality*. Retrieved from http://www.commonwealthfund.org/~media/files/publications/fund-report/2006/oct/the-role-and-relationship-of-cultural-competence-and-patient-centeredness-in-health-care-quality/beach_rolerelationshipcultcompatient-cent_960.pdf

2.1 Health Literacy, Language Access and Cultural Competence

Health Literacy

Health literacy is commonly defined as “the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions.”^{10,11,12} The Institute of Medicine (IOM) notably highlighted health literacy for the first time in its 2004 report, *Health Literacy: A Prescription to End Confusion*.¹² Health literacy affects not only a person’s ability to read and understand health information, but involves speaking, writing and math skills (e.g., calculating blood sugar levels, comparing health plan deductibles), and conceptual knowledge.^{12,3}

Health literacy affects a large proportion of the population and is not necessarily focused on specific subgroups, as “even well educated people with strong reading and writing skills may have trouble comprehending a medical form or doctor’s instructions.”¹² It is estimated that nearly half of all American adults (or 90 million people) have difficulty understanding and processing health information¹² and that only 12% of adults have proficient health literacy.^{10,13}

Health literacy broadly affects one’s ability to navigate the health system and manage conditions, and has important health and health care implications. Low health literacy has been linked to poor outcomes such as higher rates of hospitalization and use of emergency services, and less-frequent use of preventive services—all of which are associated with higher health care costs.^{12,10} Existing tools assess health literacy levels and can be used for QI, training and program planning purposes.^{14,15} However, there are important challenges, including evolving definitions¹² and questions about the usefulness of such assessments, given the near universality of the issue of health literacy and recommendations for a “universal precautions” approach.¹⁶

Language Access

The U.S. Department of Health and Human Services (DHHS) 2013 Language Access Plan defines language access as being achieved “when individuals with [limited English proficiency] LEP can communicate effectively with HHS employees and contractors and participate in HHS programs and

¹⁰ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). *Health Literacy Basics*. Retrieved from <https://health.gov/communication/literacy/quickguide/factsbasic.htm>

¹¹ Ratzan, S. C., Parker, R. M. (2000). *Introduction*. In: *National Library of Medicine Current Bibliographies in Medicine: Health Literacy*. NLM Pub. No. CBM 2000-1. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services.

¹² Institute of Medicine (IOM). (2004). *Health Literacy: A Prescription to End Confusion*. Washington, DC: The National Academies Press.

¹³ Kirsch, I.S., Jungeblut, A., Jenkins, L., Kolstad, A. (1993). *Adult Literacy in America: A First Look at the Results of the National Adult Literacy Survey (NALS)*. Washington, DC: National Center for Education Statistics, U.S. Department of Education.

¹⁴ Agency for Healthcare Research and Quality. (2016, February). *Health Literacy Measurement Tools (Revised)*. Retrieved from <https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html>

¹⁵ Boston University, Communicate Health, and the National Library of Medicine. (2017). *Health Literacy Tool Shed*. Retrieved from <http://healthliteracy.bu.edu/about>

¹⁶ Brega, A., Barnard, J., Mabachi, N., Weiss, B., DeWalt, D., Brach, C., Cifuentes, M., Albright, K., West, D. (January 2015). *AHRQ Health Literacy Universal Precautions Toolkit, Second Edition*. Rockville, MD: Agency for Healthcare Research and Quality

activities.”^{5,17} To facilitate language access, care providers, organizations and other entities may provide “language assistance,” defined as “all oral and written language services needed to assist individuals with LEP to communicate effectively with HHS staff and contractors and gain meaningful access and equal opportunity to participate in the services, activities programs or other benefits administered by the HHS.”¹⁷ An alternate view, and as framed by NASEM, is that language access “focuses on equity” and language assistance “focuses on the methods of service delivery, whether it be in-person sign language or spoken language interpreters, video remote interpreting, or remote simultaneous medical interpreting.”⁵

The issue of language access is not new, having gained national attention in the 1960s, when Title VI of the Civil Rights Act of 1964 required recipients of federal financial assistance to take “reasonable steps” to consider persons with LEP in their programs and activities.¹⁸ Language access has also expanded to include communication issues beyond LEP—including the communication needs of people with visual, hearing or speech disabilities—and as such, other important U.S. regulations also address language access (e.g., the Americans with Disabilities Act [ADA] and the U.S. Department of Justice’s regulations to implement ADA requirements).¹⁹ We discuss communication and language assistance in greater detail in Section 2.2.

It is estimated that 24.5 million people (8.6% of the population) in the U.S. have LEP.²⁰ The health implications are broad: LEP is associated with the higher risk of being uninsured, as well as medical errors and various patient safety problems, to name a few.^{6,18} The problems associated with LEP make language access critical for achieving access to care and high-quality care. The diversity of people with LEP also means that language access efforts must account for the diversity of languages spoken.

Cultural Competence

The DHHS issued a set of National CLAS Standards defining cultural competence as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.”²¹ Cultural competence may be viewed as a strategy used by health care providers, organizations and other entities to improve quality of care and reduce health care disparities, primarily by providing services that are respectful of and responsive to diverse populations, including populations that vary by race, ethnicity, culture or language proficiency.^{5,22} Cultural competence may also be viewed as the ability of—not just a strategy used by—providers and entities to provide such services.⁵

¹⁷U.S. Department of Health and Human Services. (2013). *Language Access Plan*. Retrieved from <https://www.hhs.gov/sites/default/files/2013-hhs-language-access-plan.pdf?language=en>

¹⁸U.S. Department of Health and Human Services, Office for Civil Rights. (n.d.). *Civil Rights for Individuals and Advocates Special Topics: Limited English Proficiency*. Retrieved from <https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html?language=es>

¹⁹U.S. Department of Justice, Civil Rights Division, Disability Rights Section. (2014, January). *Americans with Disabilities Act Requirements: Effective Communication*. Retrieved from <https://www.ada.gov/effective-comm.htm>

²⁰Gonzales, G. (2014, May). *Brief 40: State Estimates of Limited English Proficiency (LEP) by Health Insurance Status*. Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414189

²¹U.S. Department of Health and Human Services, OPHS, Office of Minority Health (2001, March). *National Standards for Culturally and Linguistically Appropriate Services in Health Care: FINAL REPORT*. Retrieved from <https://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>

²²Betancourt, J. R., Green A. R., Carrillo J. E., Park, E. R. (2005). Cultural Competence and Health Care Disparities: Key Perspectives and Trends. *Health Affairs*, 24(2):499-505.

The term “cultural competence” began emerging more consistently in relation to health care in the 1990s.⁹ An important driver was the increasing diversity of the U.S. population, with clinicians seeing patients with varying perspectives regarding health that were influenced by their social or cultural background.^{5,21} Another driver was the growing evidence of persistent racial/ethnic disparities in health care and the importance of providing culturally competent, patient-centered care to address these disparities and improve care quality.^{5,9,21} Two key IOM reports shone a national spotlight on these issues: 2001’s *Crossing the Quality Chasm* and 2002’s *Unequal Treatment*.^{9,21,23,24}

Outside the health policy and research world, an acclaimed 1997 book and winner of the National Book Critics Circle Award, *The Spirit Catches You and You Fall Down*, by Anne Fadiman, brought the discussion of “ways in which American medicine is practiced across cultures” further into medical and other circles, and highlighted the important difference between cultural constructs related to health and illness.²⁵

As the population of racial and ethnic minorities continues growing, the cultural competence movement is expected to continue expanding. The U.S. Census Bureau estimates that by 2020, the majority of U.S. children will be part of a minority racial or ethnic group, with the U.S. population as a whole expected to follow this trend: by 2060, the minority population is projected to rise to 56 percent of the total population—up from 38 percent in 2014.²⁶ Given the known problems associated with gaps in culturally competent health care, the implications are pronounced. There is evidence that the lack of cultural competence presents care barriers for many populations, including barriers related to cancer screenings and care, mental health diagnosis and treatment, maternal health outcomes and sexually transmitted disease.⁶ The delivery of culturally competent care will be especially salient in addressing the disparities that affect diverse populations.

2.2 Expanded Concepts Based on National CLAS Standards and Patient-Centered Care

More recent efforts to expand and align the focus of health literacy, language access and cultural competence have pointed out the interrelatedness of these concepts and suggested new terminology. One important effort is enhancement of the DHHS National CLAS Standards (revised and updated in 2013) that introduced more expansive terms relating to communication and language access, culture and understandable care.²⁷ In particular, the enhanced standards expand the concept of culture to be more explicitly inclusive of populations beyond racial and ethnic minorities. The enhancement also adds “communication and language assistance” as a theme beyond language access, to better acknowledge communication needs outside LEP. Finally, the enhancement expands the concept of understandable care

²³ Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press.

²⁴ Institute of Medicine (IOM). (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press.

²⁵ Fox, M. (2012, September 14). Lia Lee Dies; Life Went On Around Her, Redefining Care. *The New York Times*. Retrieved from <http://www.nytimes.com/2012/09/15/us/life-went-on-around-her-redefining-care-by-bridging-a-divide.html>

²⁶ Colby, S. L., Ortman, J. M. (2015, March). *Projections of the Size and Composition of the U.S. Population: 2014 to 2060*. Retrieved from <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf>

²⁷ U.S. Department of Health and Human Services, Office of Minority Health. (2013, April). *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*. Retrieved from <https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf>

to address broader aspects of care and services, and incorporates health literacy concepts. This section briefly summarizes each of these three expanded concepts.

Furthermore, because the enhanced standards broadly frame these expanded concepts in relation to longer-existing concepts of CLAS and patient-centered care, we summarize these two additional concepts.

Culture

The enhanced National CLAS Standards adapt a broader definition of culture to refer to “the integrated pattern of thoughts, communications, actions, customs, beliefs, values and institutions associated wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics.”²⁷ The enhanced definition more explicitly recognizes the broad manifestations of culture, beyond just racial and ethnic minorities, and also provides “increased opportunity...to identify and use similarities” to improve health care and quality.²⁷

Communication and Language Assistance

The enhanced standards also added the theme of “communication and language assistance,” in lieu of “language access,” to more broadly cover all communication needs, not just LEP. The enhanced standards define communication and language assistance as encompassing “all communication needs and services, e.g., sign language, braille, oral interpretation and written translation.”²⁷ This update is more specific in acknowledging the needs of people with certain disabilities and impairments—such as visual, hearing, speech and cognitive impairments.²⁷ As mentioned previously, under the definition of “language access,” “language assistance” may also be viewed as the *means* or process by which communication needs are met.⁵

Understandable Care and Services

Under the enhanced standards, understandable care and services “rely on a clear exchange of information between providers and recipients of care and services. Individuals should be able to fully comprehend how to access care and services, their treatment options and what they need to get and stay well. Ensuring that care and services are understandable is particularly important to those who have LEP, are deaf or hard of hearing or have difficulty comprehending the health care system and its terminology.”²⁷ This definition more explicitly acknowledges the same concepts that are salient to health literacy, including the importance of conceptual knowledge and comprehension and the need to ensure that health information is comprehensible even to those who may have hearing or other impairments. This definition also focuses on the responsibility of the health care organization to communicate effectively.

CLAS

The provision of CLAS has been identified as an important approach to addressing health care disparities based on race, ethnicity, culture, language needs, health literacy and communication needs.⁶ At its core, both the original and enhanced National CLAS Standards provide an organizing framework in which health care providers and organizations may provide care and services to meet the needs of diverse populations, under the reasoning that CLAS respond to demographic and other differences, reduce disparities and improve quality of care. The enhanced standards focus on areas pertaining to 1) effective, equitable, understandable and respectful care; 2) governance, leadership and workforce; 3) communication and language assistance; and 4) engagement, continuous improvement and accountability.²⁷ The standards also provide an additional framework for integrating concepts that may

address health literacy, language access and cultural competence—and acknowledge the broader definitions and interrelated constructs that may be entailed within the three concepts.

Patient-Centered Care

Simultaneous with the rise in efforts to promote health literacy, communication and language assistance and cultural competence, the concept of “patient-centered care” has gained broad support. Patient-centered care is defined in the IOM’s seminal 2001 report, *Crossing the Quality Chasm*, as a core component of quality and includes care that is “respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.”²³ The primary aim of patient-centered care is broader than that of, for example, language access or cultural competence; it emphasizes individualized care, as well as the patient-provider relationship, that may elevate quality of care for all patients—not just a cultural, linguistic or other subgroup.⁹

In the 1990s, the Picker Institute—along with the Commonwealth Fund—further defined eight dimensions (“principles”) of patient-centered care, including respect for patients’ values, preferences and expressed needs; coordination and integration of care; information, communication and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family and friends; transition and continuity; and access to care.²⁸ Many of these principles are directly related to the concepts of health literacy, language access and cultural competence. With the publication of the IOM’s 2001 report, the patient-centered care concept was notably “enshrined” and pushed into prominent, national discussion.²⁹

Patient-centered care may be applied at many levels, not just that of the patient-provider relationship, including that of a health care practice, a hospital, a health care plan or system.^{9,27} This philosophy of patient-centered care involves an organizational focus that incorporates patient’s individual needs and preferences through all levels of care delivery and the care system. Indeed, the patient-centered medical home (PCMH) has currently evolved as a promising model for improving health care and redefining how primary health is organized and delivered.³⁰

2.3. Common Themes in Evidence

There is a growing body of evidence of effective interventions for addressing health literacy, communication and language access, cultural competence and patient-centered care. These interventions improve patient understanding and engagement in health care, and improve the quality of care delivered and outcomes attained. Exhibit 2 summarizes the evidence for these successful interventions. Common themes include the following:

- Using interactive methods.
- Communicating with patients in their preferred language or using trained interpreters.
- Providing written information and visual or multi-media aids.
- Engaging community health workers.
- Delivering patient-centered care.

²⁸ Picker Institute. (n.d.). *Principles of Patient-Centered Care*. Retrieved from <http://pickerinstitute.org/about/picker-principles/>

²⁹ Epstein, R., & Street R. L., J. (2011). The values and value of patient-centered care. *Annals Of Family Medicine*, 9(2), 100-103.

³⁰ Agency for Healthcare Research and Quality. Patient Centered Medical Home (PCMH) Resource Center. (n.d.), *Defining the PCMH*. Retrieved from <https://pcmh.ahrq.gov/page/defining-pcmh>

Each of these interventions has been shown to improve health behaviors and health outcomes. Organizations can implement evidence-based practices to communicate clearly and in plain language, whether in-person, over the telephone or in written materials and other media, to increase patient understanding and engagement in their care. Engagement of the community, including community health workers, can support this effort. Chapter 3 builds on these evidence-based practices to suggest an integrated approach to measurement that can align the core concepts health literacy, communication, culture and patient-centered care.

3.0 PROPOSED FRAMEWORK FOR MEASURE ALIGNMENT

We propose a framework to integrate measurement of health literacy, language access and cultural competence that can be used to improve care quality and reduce disparities (Exhibit 3). In Exhibit 3, we present domains common across these concepts, based on review of authoritative government sources and seminal literature. For each domain, the exhibit summarizes the components, activities or expectations based on these authoritative sources and, where relevant, evidence-based interventions that have been demonstrated to address health literacy, improve cultural competence, patient understanding and patient engagement. We posit that well-aligned components are strong candidates for integrated, patient-centered measurement. Although the original charge for this paper was to suggest an integrated framework for measurement of health literacy, cultural competence and language access, we have applied the broader terms or meanings as described in the enhanced National CLAS Standards, including communication and language assistance, and we include patient-centered care as a complementary and expansive approach to addressing similar or related concerns.

3.1 Integrated, Patient-Centered Framework Based on Common Domains

To develop an integrated framework for measurement, we considered the evidence as well as standards or other authoritative guidelines for providing care designed to address the concepts of health literacy, communication and language access and cultural competence, and we added the concept of patient-centered, both because it is reflected in the Enhanced National CLAS Standards and because it shares so many domains common to these other concepts. The framework illustrates how these concepts share common components, activities and expectations across multiple domains. For many of these concepts, we refer to the National CLAS Standards. The provision of CLAS has been identified as an important approach to addressing health care disparities based on race, ethnicity, culture, language needs, health literacy and communication needs.⁶ Both the original and the enhanced standards provide an organizing framework in which health care providers and organizations may provide care and services to meet the needs of diverse populations. Below, we present standards, activities, expectations or guidelines for each concept. These standards, promulgated by authoritative sources, and the evidence-based interventions identified previously, are well-aligned across a common set of domains. Exhibit 3 displays this alignment.

We group activities/expectations across the concepts of health literacy, communication and language assistance, cultural competence and patient-centered care into seven contextually relevant domains:

- Organization culture/values
- Accountability and QI
- Workforce skills
- Assessment
- Community engagement

- Communication
- Patient engagement

It may be possible to group activities or expectations in alternate ways, but for discussion, we describe the following domains and subdomains:

Organization Culture/Values

The enhanced National CLAS Standards added a standard to the original set and expanded the scope of two other standards, to emphasize the important role of governance and leadership in promoting “effective, equitable, understandable, and respectful quality care and services” (CLAS Standard #2).²⁷ This construct integrates the role of organizational culture in making health care services culturally sensitive and understandable to people with LEP and people with low health literacy. The PCMH similarly identifies physician leadership of the care team as central feature of the model,³¹ whose purpose is to “foster an environment of trust and respect.”³² In both cases, the function of leadership is highlighted in creating a culture of respect and inclusion. Additional expectations for organizational culture and leadership include making the health care system more proactive in removing health literacy barriers and implementing incentives to promote good communication practices³³ and to implement patient-centered care principles.³¹

Accountability/QI

National CLAS Standards,²⁷ National Academy’s *Prescription to End Confusion*,¹² the CDC’s training materials on health literacy³⁴ and the *Joint Principles of the Patient-Centered Medical Home*³¹ all highlight the importance quality measurement, QI and accountability in implementing and continually improving the effectiveness of health literacy, cultural competence, communication and language assistance and patient-centered care. CLAS Standard #10 is “Conduct Organizational Assessments” to assess progress in implementing the CLAS standards. Ongoing assessment of efforts to improve health equity and reduce disparities is key to providing continuous process improvement and focusing resources on proven outcomes. Suggested activities include developing plans, policies, goals and management accountability for CLAS; collection of data (patient and community demographics, quality performance); stratification of quality measures by demographic group; organizational self-assessment of capacity to provide CLAS and progress on CLAS activities.

In addition to assessment, accountability/QI includes continuous improvement activities, public reporting and seeking third-party external recognition. When organizations take time to gather robust baseline

³¹ American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). (2007, March). *Joint Principles of the Patient-Centered Medical Home*. Retrieved from http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf

³² Scholle, S. H., Torda, P., Peikes, D., Han, E., Genevros, J. (2010, June). *Engaging Patients and Families in the Medical Home*. Retrieved from <https://pcmh.ahrq.gov/sites/default/files/attachments/Engaging%20Patients%20and%20Families%20in%20the%20Medical%20Home.pdf>

³³ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National Action Plan to Improve Health Literacy*. Retrieved from https://health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pdf

³⁴ Centers for Disease Control and Prevention. (n.d.). *Welcome to Health Literacy for Public Health Professionals*. Retrieved from <https://www.cdc.gov/healthliteracy/training/index.html>

information about their populations, capabilities and processes, ongoing data regarding performance and outcomes can be collected for future analysis and QI.

Workforce

Workforce preparedness through recruitment and training has been highlighted as an important domain across all these concepts. Subdomains include:

- Diverse workforce.
- Training/ workforce skills.

Diverse Workforce

The National CLAS Standards, echoed by the DHHS Office of Inspector General, specify recruitment of a diverse workforce at all levels of the organization as valuable for providing culturally and linguistically sensitive care and services.^{27,35} The National CLAS Standards present the rationale for a diverse workforce that includes creating a welcoming environment for culturally diverse individuals (staff and patients); engaging with the community; providing diverse perspectives into the CLAS program and other decision making; and expanding staff knowledge and experience. The Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities additionally notes the value of community health workers in extending an organization's capacity for CLAS.³⁶

Training and Workforce Skills

Hiring a diverse workforce is valuable for delivering culturally and linguistically appropriate services, but it is not enough. Ongoing training and skill development is recognized across concepts as an important strategy to ensure that staff understand the expectations for performance and have the skills to deliver culturally and linguistically sensitive care and services (CLAS Standard #4).²⁷ Epstein and Street, in a 2011 editorial in *Annals of Family Medicine*, argue that training is required to shift the physician's traditionally authoritative role to a more collaborative and empathic role that invites patient engagement.²⁹ The skills needed for this role change have much in common with the skills needed to engage a diverse patient population as participants in their health care.

Assessment

Needs assessment is at the core of providing individualized care and services. Numerous authorities identify assessment as a critical component of providing services that are understandable and tailored to the needs, culture and language of the patient.^{33,27,12,10} Assessments can inform service and resource planning at the organization level, as well as for tailoring individual care plans. The National CLAS Standards also recommend conducting organization assessments; however, because this activity is linked to QI, we have addressed that requirement in the Accountability/Quality Improvement domain. Assessment subdomains include:

- Individual

³⁵ Department of Health & Human Services, Office of Inspector General. (2010, July). *Guidance and Standards on Language Access Services: Medicare Providers*. Retrieved from <https://oig.hhs.gov/oei/reports/oei-05-10-00050.pdf>

³⁶ Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities. (2015, June). *CLAS Standards Training Toolkit: Facilitators' Guide for Outreach Workers*. Retrieved from http://dhmh.maryland.gov/mhhd/Documents/Toolkit_for_Outreach_Workers.pdf

- Community

Individual Assessment

The National CLAS Standards (Standard #11)²⁷ and the CDC³⁴ recommend collecting demographic data, such as race, ethnicity and language, to identify individual needs, better tailor services and evaluate care outcomes and utilization patterns. The IOM recommends health literacy assessment.¹² Capturing information about individual patient needs, cultural context and language allows the organization to provide responsive services to the individual and to monitor the quality and effectiveness of services provided. Epstein and Street posit that assessment of the patient's values, preferences and beliefs is important to developing shared understanding and improving the quality of healthcare decisions.²⁹

Community Assessment

National CLAS Standard #12 proposes conducting regular assessments of community health assets and needs for planning services that address the diversity of the population.²⁷ This proposition is echoed by the Office of Inspector General,³⁵ and the CDC similarly recommends assessing the literacy level of the audience, to better design and tailor communications.³⁴

Community Engagement

National CLAS Standard #13 suggests engaging the community to help develop, implement and evaluate CLAS policies, practices and services.²⁷ The CDC similarly recommends involving representatives from the community in developing and evaluating health information, and to promote interest in health literacy.³⁴ The U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, likewise recommends engaging the community in development and provision of culturally and linguistically appropriate health education and information services.³³ Epstein and Street suggest that patient-centered care practices engage patients, families and other stakeholders in developing measures to evaluate patient-centered care, to ensure such measures reflect what matters to the community.²⁹

Communication

The Institute for Healthcare Communication presents evidence of the impact of communication in the healthcare setting.³⁷ They describe studies that tie communication effectiveness to diagnostic accuracy, patient adherence to treatment, patient safety and patient and team satisfaction. Patient-centered care principles and shared decision-making depend on effective and supportive communication.³⁸ The National CLAS Standards identify communication as key to avoiding malpractice, and the provision of CLAS as key to effective communication and reduction of disparities.²⁷ Subdomains include:

- Materials
- Oral communication

Materials

The IOM recommends presenting health information in various forms and media, and in clear, every-day language.¹² The U.S. Department of Health and Human Services, Office of Disease Prevention and Health

³⁷Institute for Healthcare Communication. (2011, July). *Impact of Communication in Healthcare*. Retrieved from <http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/>

³⁸Street, J.L., Makoul, G., Arora, N.K., & Epstein, R.M. (2009). How does communication heal? Pathways linking clinician-patient communication to health outcomes. *Patient Education and Counseling*, 74(3), 295-301.

Promotion recommends using plain language, making written information look easy to read, supplementing written information with pictures, and ensuring materials reflect the cultural context, language and language skills of the intended users.^{10,33} National CLAS Standards #6 and #8 recommend providing written notice of the availability of language services, and providing easy-to-understand print and multimedia materials and signage in peoples' preferred language, or the languages commonly used in the community.²⁷ The Centers for Disease Control and Prevention (CDC) suggests using culturally and linguistically appropriate messages,³⁴ and The Joint Commission recommends providing patient education materials that "meet patient needs."³⁹

Oral Communication

The IOM and the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion recommend using everyday language and avoiding jargon,^{12,33} and the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion and Epstein and Street recommend using interactive methods to directly engage patients.^{10,29,40} National CLAS Standard #5 suggests offering both language assistance services to people with LEP, and other communication supports, at no cost to the individual.²⁷ The National CLAS Standards also recommend making verbal offers of language assistance, in addition to written offers. CLAS Standard #1 suggests providing understandable care and services that are culturally responsive in peoples' preferred languages, and with any communication assistance required.²⁷

Patient Engagement

The IOM identifies several approaches to engaging patients. These include providing time for discussion between patients and providers and helping patients to feel comfortable asking questions within a therapeutic relationship.¹² National CLAS Standard #1, while overarching, also points to engaging patients; Standards #5 and #7 address the provision of language services and ensuring the competency of language service providers as a vehicle to promote and enhance patient engagement.²⁷ The Joint Commission recommends that health care organizations "accommodate patient cultural, religious or spiritual beliefs and practices."³⁹ The Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities recommends using collaborative care and shared decision-making.³⁶ Epstein and Street recommend physicians display specific behaviors to ensure patients are engaged in their care,²⁹ and the *Joint Principles of the Patient-Centered Medical Home* also identify patient involvement in decision-making as a core principle of the PCMH model.³¹

4.0 MEASUREMENT OPPORTUNITIES AND CHALLENGES

In this chapter, we identify measurement opportunities and challenges based on the framework identified above. First, we review the landscape of existing measures for structure, process and outcome. Next, we identify measure gaps and describe the trade-offs between using an integrated approach to measurement

³⁹The Joint Commission. (2010). *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Retrieved from <http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>

⁴⁰ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). *Improve the Usability of Health Information*. Retrieved from <https://health.gov/communication/literacy/quickguide/healthinfo.htm>

and using independent and specific-focus measures. Finally, we describe the application of an integrated measurement frameworks in various settings.

4.1 Existing Measures Address Health Literacy, Communication and Language Assistance and Cultural Competence

Health care quality measures can assess structures, processes and outcomes.⁴¹ Structure refers to the infrastructure and capability of health care organizations (such as workforce and health information technology). Process measures evaluate the provision of evidence-based or recommended services. Outcomes are the endpoints and effect of care—they can include care experiences and health outcomes such as disease control or mortality and can be measured for individuals or a population.

A recent scan of existing measures found a limited number of measures addressing health literacy, communication and language assistance and cultural competence,⁴² and even more limited use of these measures in accountability efforts. In this section, we highlight how these existing measures relate to the proposed framework.

Structure measures

Several kinds of measures are available for assessing structures of care, including organizational surveys, accreditation standards and program requirements (Exhibit 4).

Surveys Two surveys, both endorsed by the National Quality Forum, address all the domains from our integrated, patient-centered framework, but one focuses primarily on culture and language. The RAND Cultural Competency Implementation Measure⁴³ is an organizational survey designed for web-based administration. This survey was based on a priority subset of the (National Quality Forum's) NQF's cultural competency preferred practices; most items are framed in relation to disparities or cultural competence (e.g., "Provided staff with time and resources for training programs and practices that promote culturally competent care"). In contrast, the Communication Climate Assessment Toolkit (C-CAT) addresses a range of communication issues including health literacy, culture, language access and other communication barriers.⁴⁴ Originally developed by the American Medical Association Ethical Force program and now stewarded by the University of Colorado, this toolkit includes surveys for clinicians/staff and patients, and the measures for each composite are calculated from both sets of responses. We could not locate information on use of either measure in accountability programs.

Accreditation programs Existing accreditation standards for health care organizations also address the topics and domains of our proposed framework. A previous review of accreditation standards found that several accreditation programs ask organizations to demonstrate attention to health literacy, cultural competence and communication and language assistance.⁴² However, organizations can often achieve

⁴¹ Donabedian, A. (2005). Evaluating the Quality of Medical Care. *The Milbank Quarterly*, 83(4), 691-729.

⁴² Ng, J., Tirodkar, M., Briefer French, J., Spalt, H., Ward, L., Haffer, S. C., Hewitt, N., Rey, D., Hudson Scholle, S. (2017). Health Quality Measures Addressing Disparities in Culturally and Linguistically Appropriate Services: What Are Current Gaps? *Journal of Health Care for the Poor and Underserved*. Forthcoming

⁴³ National Quality Forum. (2012, August 10). *NQF Endorses Healthcare Disparities and Cultural Competency Measures*. Retrieved from http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Healthcare_Disparities_and_Cultural_Competency_Measures.aspx

⁴⁴ University of Colorado, Center for Bioethics and Humanities (n.d.). *About C-CAT*. Retrieved from <http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BioethicsHumanities/C-CAT/Pages/About-C-CAT.aspx>

accreditation without meeting specific program elements related to our framework, such as collection of race/ethnicity data.

Hospitals. The Joint Commission's accreditation program for hospitals addresses several elements of the framework, primarily around data collection and addressing communication needs. The program specifically addresses communication barriers, language needs and culture. There are standards that address domains of organization culture, accountability and QI and workforce, but they do not speak to their application to health literacy, cultural competence or communication and language assistance concepts.³⁹

Health plans. NCQA's Health Plan Accreditation⁴⁵ considers language needs, health literacy and other communication needs primarily related to health plan operations, care management and network adequacy. NCQA also has a Multicultural Health Care Distinction program⁴⁶ that was developed in 2010 to align with the HHS OMH CLAS standards. This program adds an emphasis on culture, language and disparities through requirements for data collection on race/ethnicity and language, increased expectations for language services and requirements for QI efforts related to reducing disparities or increasing cultural competence. It has not been revised since publication of the revised HHS OMH CLAS standards in 2013. Uptake of this specialized program is limited; of more than the 1,200 currently NCQA-Accredited health plans, only 27 have NCQA's additional Distinction in Multicultural Health Care.⁴⁷

Primary care practices. NCQA's PCMH Recognition program for primary care practices includes expectations for addressing health literacy, cultural competence and communication and language assistance, and the standards address all domains of the integrated framework. As in other accreditation programs, practices can achieve recognition without meeting all elements. Data from practices recognized under the 2014 standards show that most met expectations for documentation of race/ethnicity and language needs, though only about 40% document health literacy assessment. Nearly all have mechanisms for referring to community resources, but only 40% assess the usefulness of community resources. About half of the recognized practices (52%) conduct QI efforts focused on vulnerable populations.⁴⁸

The recently released 2017 version of the PCMH standards⁴⁵ increases expectations relevant to our proposed framework. New expectations specifically call out building a "health-literate" practice with training and demonstration of communication processes like Teach-Back methods; educating staff on how to interact with people of different cultures or language needs and addressing potential disparities based on these and other patient characteristics. Still, few of these items are core or required elements; practices choose how to achieve the required number of credits for recognition.

Program standards. Another example of program standards addressing our integrated, patient-centered framework comes from the Merit-Based Incentive Payment System (MIPS) recently introduced for Medicare clinicians, which offers incentive payments based in part on performance in four areas: quality,

⁴⁵ National Committee for Quality Assurance. (2017). *Patient-Centered Medical Home (PCMH) Recognition*. Retrieved from <http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx>

⁴⁶ National Committee for Quality Assurance. (2010). Multicultural Health Care Distinction. Retrieved at <http://www.ncqa.org/programs/other-programs/multicultural-health-care-distinction>

⁴⁷ National Committee for Quality Assurance. (2017). Multicultural Health Care Distinction Report Card. Retrieved at <http://www.ncqa.org/report-cards/other-healthcare-organizations/multicultural-health-care-distinction>

⁴⁸ Christensen, K., Tirodkar, M., Scholle, S. H. (2017). *Addressing Social Risk in the PCMH: A Review of Current Practice*. Manuscript in preparation

costs, clinical practice improvement activities and advancing care information (meaningful use of electronic health records).⁴⁹ Most participants will be required to attest that they completed up to 4 improvement activities for a minimum of 90 days, and this will count toward 15% of the performance score. Payments to clinicians will be based in part on their completion of up to 4 QI activities, which may be selected from a list of 93 topics, of which only 4 fall under the category “achieving health equity”:

- Engagement of new Medicaid patients and follow-up.
- Leveraging a Qualified Clinical Data Registry (QCDR) for use of standard questionnaires (for disparities reduction).
- Leveraging a QCDR to promote use of patient-reported outcome tools.
- Leveraging a QCDR to standardize processes for screening.

Other QI activities included in categories of population management and beneficiary engagement align with the integrated, patient-centered framework (Exhibit 4). Several activities are related to topics extraneous to this framework, but could be used as models or adapted to address health literacy, communication and language assistance and cultural competence. For example, current improvement activities that relate to staff training (IA_PSPA_3: Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS[®] or other similar activity) or assessment of organizational safety culture (IA_PSPA_4: *Administration of the AHRQ Survey of Patient Safety Culture*) could be adapted for training in health literacy, communication and language assistance and cultural competence.

Process Measures

Only a handful of measures are available to evaluate the process of care delivery related to our integrated, patient-centered framework and concepts (Exhibit 5). Most address communication and language assistance and focus on specific health care settings. One measure is used in accountability programs: Medicare health plans and prescription drug plans are evaluated on the availability of communication services for members who call the health plan. There is a suite of measures developed for assessing the use of language services in hospitals, although its NQF endorsement has lapsed. The Institute for Clinical Systems Improvement (ICSI) has published a measure targeting use of Teach-Back methods for QI purposes.

Outcomes

A previous review⁴² identified several survey tools available for assessing patient experience with communication, including a special focus on interpreters and cultural competence. However, we found that the only item used in accountability programs is a composite measure assessing communication about medications from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Literacy item set.⁵⁰ This composite is used in CAHPS surveys for hospitals, accountable care organizations and other facilities; it is also in the CAHPS survey as a measure reporting option for the MIPS for Medicare providers as well.

⁴⁹ Centers for Medicare & Medicaid Services (CMS). (n.d.; b) *Quality Payment Program: Learn About the Program*. Retrieved from <https://qpp.cms.gov/learn/qpp>.

⁵⁰ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2016, April). *Supplemental Items for the CAHPS Clinician & Group Survey*. Retrieved from <https://www.ahrq.gov/cahps/surveys-guidance/item-sets/cg/index.html>

Yet, validated items in the CAHPS family of measures address a broad range of topics related to cultural competence, including interpreter services, health literacy and patient-centered medical home (Exhibit 6). Each item set was developed separately, using different conceptual frameworks. Eight items addressing communication are common to the health literacy and cultural competence item sets; the Cultural Competence set includes additional items that address trust, experiences of discrimination, interpreters and complementary and alternative medicine; the Health Literacy Set has items related to topics such as test results, filling out forms and self-management support (refer to Exhibit 7 for examples).

Measurement Gaps

Although existing measures cover every domain of the proposed framework, they leave critical gaps. The two structural measures that are most comprehensive—the Communication Climate Assessment Toolkit and the Cultural Competency Implementation Measure—are not widely used, and both depend on intense data collection and organizational self-report, which is not sufficiently reliable to support accountability. Other structural measures, such as accreditation programs, include relevant content; however, organizations can achieve accreditation without addressing the relevant measures of health literacy, communication and cultural competence. Finally, while these measures address the targeted concepts, several are outdated and do not reflect current thinking about the broader concepts of communication or culture, nor address care barriers experienced by sexual and gender minorities or people with disabilities.

As described, existing process measures related to health literacy, communication and cultural competence are even more limited: four measures address only two domains (language services and health literacy/patient understanding). It may be possible to develop additional process measures, but there are significant challenges to their implementation as accountability measures. Health care organizations have little appetite for new measures unless they replace existing ones. More important, the NQF, which endorses measures, requires strong evidence demonstrating a link between specific processes and beneficial outcomes. Such evidence is generally codified in evidence-based practice guidelines, but in a previous environmental scan, we found no such guidelines.⁶ Although we have cited evidence for some common interventions, such as the use of community health workers (Chapter 3), the evidence is not specific enough to support process measures. For example, there is wide variation in the roles, skills and activities performed by community health workers. Without evidence for specific, measurable interventions, it is impossible to specify measures to capture the essential elements of the community health worker intervention.

Nevertheless, process measures can help internal QI and workflow design by demonstrating how to build on structures to achieve desired outcomes. New process measures may not be useful as accountability measures, but they could support organizational improvement efforts.

Relevant, validated patient experience items (Exhibit 7) are available, but miss key issues related to culture, such as involvement of the patient's family in health care decisions. In addition, current methods for capturing patient experience, including sampling approaches and survey administration, limit their utility in capturing information from the populations most at risk. Surveys are available in limited languages; survey methods do not provide for sampling based on use of, or need for, communication support. Finally, surveys are currently administered by mail or telephone, limiting their ability to capture timely, relevant experience from the most relevant segments of the population.

Trade-Off Between Integrated and Independent Specific-Focus Measurement Approaches

Specific-focus measures and broad, integrated measures each have benefits and drawbacks. In any system of measurement, the more measures there are, the more “diluted” any single measure becomes. Where there are many measures, value-based purchasing systems, such as CMS' MIPS, often allow providers to self-select measures they will report.⁴⁹ For example, in the MIPS providers can choose any 4 of 92 activities, entirely bypassing improvements in health equity. This allows providers to avoid important measures that are potentially difficult to implement, or for which their performance lags. Integration of

measures limits providers' ability to choose one, or a limited set, of independent and specific-focus measures, and increases the breadth of measurement. The trade-off of a broader, more integrated set of measures is loss of specificity.

An integrated measurement approach for public reporting or value-based purchasing does not preclude the use of more detailed or independent and specific-focus measures. To mitigate the risk of domains losing "weight" (importance), providers and organizations may continue to use detailed, specific-focus measures for internal QI purposes and use a broader, integrated approach for public reporting. An integrated approach does not interfere with selecting more detailed and focused measures for QI efforts, and may also have more appeal and uptake in value-based purchasing because of its breadth. This two-part approach offers a significant benefit: Organizations can report a smaller set of integrated measures publicly or for value-based purchasing programs, although to improve performance, they will need to "drill down" to identify specific opportunities for improvement. This improvement-focused effort can use more targeted measures; however, because they are used for internal improvement rather than for benchmarking or payment incentives, they can be customized to the organization's context, and need not meet the same rigorous demands as measures used for public reporting and accountability.

4.2 Application of the Integrated, Patient-Centered Framework in Different Settings

Care that focuses on the patient's values, needs and priorities (patient-centered care) crosses every type of health care provider and organization. Specific activities and interventions vary by type of organization (e.g., emergency department vs. primary care practice vs. health plan), but the issue measured can be consistent and aligned across settings, even where the role and approach may differ. In addition, even if specifications for a measure vary by setting—for example, definitions of the measure denominator, data sources for the numerator—the inherent measure content would be consistent. For example, if a measure's intent is to assess whether a provider or organization gathers information on the primary spoken language of its patients, the measure specifications would be expected to differ by setting. For a health plan, the measure denominator would cover its entire membership; in a primary care practice, it would cover patients seen by the practice. In both cases, the measure numerator addresses whether information is gathered about patients' primary spoken language (the measure intent, despite denominator differences, remains consistent across settings).

Similarly, a measure's data sources may differ by setting. For example, if a measure assesses whether an organization collects information about the race and ethnicity of patients, a primary care practice might ask patients directly. A health plan might combine direct inquiry with imputation methods to capture information about a population with whom it has had no direct contact. In both cases, despite the use of different data sources—and the advantages or disadvantages these differences offer—the measure intent is to assess whether the organization captures information about race and ethnicity.

Safety-net organizations and public hospitals that have a history and depth of experience in providing health literate and culturally and linguistically appropriate care would likely perform well on integrated measures. There is some evidence that among PCMH practices, federally-qualified health centers (FQHC) are more likely to have assessed health literacy than hospitals or private practices,⁵¹ and community health centers (including FQHC) are more likely to offer culturally and linguistically appropriate services

⁵¹ Christensen, K., Tirodkar, M.A., Scholle, S.H. (2017). Addressing Social Risk in the PCMH: A Review of Current Practice. Unpublished Manuscript.

than small private practices and hospitals.⁵² Demonstrating the connection between safety-net providers' performance of these activities and integrated measures could improve acceptance and adoption of the integrated framework.

There may be a logical order for implementing measures in different settings, based on the availability of relevant data. Staging considerations are addressed in Chapter 5: Recommendations and Next Steps.

5.0 Recommendations

This chapter recommends five strategies for using an integrated, patient-centered framework to guide broader implementation and evaluation of these critical aspects of care:

1. Use structure measures to build capacity and demonstrate capability to serve diverse population needs.
2. Develop streamlined tools and new techniques to gather patient experiences.
3. Stratify existing quality measures to target improvement and equity.
4. Develop packages of measures for vulnerable subpopulations.
5. Use independent, specific-focus measures to drill down for QI purposes, and to support performance on integrated measures used for public reporting.

We describe each strategy in detail below and offer considerations for their implementation.

Despite the existence of relevant measures addressing the concepts of health literacy, communication and language assistance and cultural competence, their uptake in existing programs and accountability efforts has been limited.

These strategies may be implemented in a different order depending on organizations' experience, the availability of relevant data, and the data collection structures or processes that are in place in a given setting. For providers and organizations inexperienced with collecting or using data to serve diverse population needs, it may be simplest to start with the first strategy—use structure measures—to build and demonstrate capacity before moving on to develop measures for vulnerable populations or gather information on patient experiences (second and fourth strategies). Once more data have been accumulated, the organization will be better able to stratify existing measures and use more detailed measures for QI purposes and to support integrated measures (fifth strategy).

Providers and organizations that are further along – those with data structures in place and already using quality measures – may be ready to implement some of the latter strategies described, such as stratification, enhanced collection of patient experience information and/or measures aimed at vulnerable groups (second to fourth strategies). Finally, organizations that are most experienced collecting and stratifying existing measures and monitoring performance with vulnerable subpopulations may be ready to implement the layered use of detailed measures to drill down for QI purposes (fifth strategy), which can also support performance on potential integrated measures used for public reporting.

⁵² Tirodkar, M.A., Porter, S., Whiting, T., Monahan, P., Saunders, R., Scholle, S.H. (2014). There is more than one way to build a medical home. *Am J Manag Care*. 2014;20(12):e590-e597

The following section gives more details for each strategy. Where relevant, we briefly describe additional work that is needed to apply the integrated, patient-centered framework to the adaptation and development of measures for QI and accountability.

1. *Use structure measures to build capacity and demonstrate capability to serve population needs.*

All the domains of the integrated framework can be evaluated using structure measures—and indeed, these structures are foundational. An adequate health information infrastructure is needed to support assessment and tracking of patient needs and care activities and QI. A trained and diverse workforce is critical for delivering evidence-based practices such as Teach-Back, and for bridging across communities of different cultures. In fact, structure measures are likely the only feasible way to encourage implementation of some framework domains, such as organizational culture and community engagement. The ability to provide adequate communication and language supports should be a universal expectation, regardless of the population served.

Existing structure measures vary in the degree to which they support the full range of the integrated framework, but there are good options for immediate implementation. Several existing measures address key structures related to the seven common domains or important outcomes. The Communication Climate Assessment Tool offers an integrated approach for surveying clinicians and staff about these concerns and maps well to the integrated, patient-centered framework. While this tool is primarily intended for internal QI efforts, it could be a useful method for assessing implementation of the framework. NCQA's 2017 PCMH program illustrates how the integrated, patient-centered framework could be implemented in standards—in some cases, the concepts of health literacy, communication and language assistance and cultural competence are separate elements (e.g., training and staff preparation, data collection), in some they are considered in tandem (e.g., care management and self-care). Both the RAND Cultural Competence Assessment tool and NCQA's Multicultural Healthcare Distinction program have a narrower framing that would need to be expanded to address a broader definition of cultural and communication needs.

Adoption of specific measures, including the health equity improvement activities included in the MIPS, or adaptation of other measures to health equity-related concepts, is one pathway to implementing relevant structural measures. The challenge in this approach is that selecting these measures and improvement activities is voluntary, and that health care providers and organizations are more likely to select measures that apply to a large segment of the population served, and that are well aligned with payer requirements. These measures already exist, and history has shown they have little traction.

A second pathway is implementation of patient-centered care models. The MIPS offers full credit for improvement activities to practices that are recognized PCMHs. Patient-centered care is highly aligned with multiple payer priorities. Expressed as “patient and family engagement,” it is one of 6 priorities articulated in the National Quality Strategy.⁵³ Nearly half of all states (22) require PCMH certification for participation in certain incentive programs, including federally run initiatives such as Comprehensive Primary Care Plus, State Innovation Models, health homes and Delivery System Reform Incentive

⁵³ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2016). *CMS Quality Strategy*. Retrieved from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf>

Payment Programs.⁵⁴ The uptake of patient-centered care principles is reflected by the growth of NCQA's PCMH Recognition program, which recognizes 12,000 practices covering 60,000 clinicians.⁴⁵

The attention to patient-centered care creates an opportunity. As we discussed, PCMHs are highly aligned with the concepts of health literacy, cultural competence and communication and language assistance. While there is limited appetite among providers and health care systems to implement new measures or to adopt measures that address a relatively narrow segment of the population served, there is growing interest, spurred by federal, state and private payer incentives, in patient-centered care models. This interest can be leveraged to drive attention to domains common across these other concepts.

Implementing structural measures may be the most immediately available opportunity, due to interest in patient-centered care and alignment of payer incentives promoting PCMH adoption. This broader approach holds appeal for providers and health care organizations because it is relevant to the entire population, and it offers the added benefit of providing an integrating framework for the concepts of health literacy, cultural competence and communication and language assistance. Research to demonstrate the benefits of PCMHs for the general population, for improving health equity—and particularly, for addressing the cultural and communication needs of vulnerable populations of interest, will strengthen the momentum of this approach.

2. Develop streamlined tools and new techniques to gather patient experiences.

While structure measures lay the foundation for integrated, patient-centered care, patients and families are the authorities on whether care achieves the goals of patient-centered, culturally responsive, understandable care. Survey tools for assessing these topics exist but have not gotten widespread use. Current approaches for collecting patient experience data use broad-based tools, target a representative sample of the population and rely on inexpensive methods (mailed surveys, sometimes with telephone follow-up). Specific needs, such as communication and language support, are not captured, or an insufficient number of individuals with such needs are sampled.

While survey response rates are declining across the general population, this may be a particularly acute problem for linguistic and cultural minorities, since cultural and language barriers could contribute to even lower participation among these groups.

Existing items addressing evidence-based communication methods, language support, discrimination and trust could provide critical information for guiding QI and supporting accountability. Efforts are needed to streamline these tools to identify a limited suite of items that target specific, actionable concepts in patient-centered care and to guide improvement efforts need to engage and support patients in being active participants in their health and health care.

More important, however, are alternative approaches for capturing the experiences of targeted subgroups. This may require fielding special surveys of vulnerable groups or identifying other modes for data collection, including electronic data collection or surveys conducted in collaboration with community organizations. While validated surveys are a critical tool, other mechanisms to obtain feedback may also be needed, particularly when there are language, communication and other barriers.

Streamlining patient experience items and developing more agile approaches to collecting patient experience information about targeted cultural and communication issues will require time, effort and

⁵⁴ NCQA (n.d.).

resources. Stakeholders will be needed to help identify the most salient items and to negotiate their selection, given the strong constituencies for each item set. Researchers will need to develop new methods to identify the relevant population to sample. It may be currently possible to survey patients who have requested language services, but a broader net may need to be cast to obtain feedback from patients who might benefit from communication assistance but did not know how to ask for it. Organizations may need to first overcome challenges in collecting demographic data before better approaches to identifying the sample frame can be implemented.

3. *Stratify existing quality measures to target improvement and equity.*

The ultimate goal of an integrated, patient-centered framework is to achieve equity in health care and outcomes across populations with diverse needs. We recommend stratifying existing clinical process and outcome measures by various social risk factors, to assess the presence and magnitude of disparities and to monitor changes over time. Stratified reporting of quality results on existing measures reported by health plans, hospitals and other provider organizations and facilities is a powerful way to identify and target opportunities for improvement.

Implementing stratified data reporting requires substantial effort. Minnesota Community Measurement first published an equity report on health care outcomes in 2015, seven years after it began efforts to increase documentation of race, ethnicity, language and country of origin.⁵⁵ Prior to public reporting, organizations could see and compare their private results with others so they could understand and build improvement efforts to address findings. Its report documents disparities in quality on five outcome measures for adults across medical groups in Minnesota; it also highlights clinics that serve higher proportions of vulnerable populations.

Similar efforts to publish data on health care equity are underway in California.^{56,57} Over the past year, CMS has released three reports on disparities in Medicare Advantage health plans, using data on quality and patient experiences.⁵⁸ Although there are several helpful and detailed toolkits for collecting race, ethnicity and language data, and although collection of these data has been encouraged for many years, data are substantially incomplete.^{59,60}

Incomplete information on social risks limits opportunities for stratified reporting. Ng et al. recently showed that most health plans – commercial, Medicaid and Medicare – lack complete data on race,

⁵⁵ MN Community Measurement. (2017, February 2). 2016 Health Equity of Care Report: Stratification of Health Care Performance Results in Minnesota by Race, Hispanic Ethnicity, Preferred Language and Country of Origin. Retrieved from <http://mncm.org/wp-content/uploads/2017/02/2016-Health-Equity-of-Care-Report-2.2.2017.pdf>

⁵⁶ California Department of Public Health. (2016). *Let's Get Healthy California*. Retrieved from <https://letsgethealthy.ca.gov>

⁵⁷ California Department of Health Care Services, Managed Care Quality and Monitoring Division. (2017). *The Managed Care Performance Dashboard*. Retrieved from: <http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx>

⁵⁸ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Minority Health, RAND Corporation. (2017, April). *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage*. Retrieved from <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Health-Disparities-Racial-and-Ethnic-Disparities-by-Gender-National-Report.pdf>

⁵⁹ Hasnain-Wynia, R., Pierce, D., Haque, A., Hedges Greising, C., Prince, V., Reiter, J. (2007). *Health Research and Educational Trust Disparities Toolkit*. Retrieved from hretdisparities.org

⁶⁰ MN Community Measurement. (2010). Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups. Retrieved from http://mncm.org/wp-content/uploads/2013/04/Handbook_on_the_Collection_with_Addendum_10.21.10.pdf

ethnicity and language needs of members.⁶¹ For the Medicare Advantage reports, CMS used statistical methods to attribute race and ethnicity where data were incomplete using other Medicare and US Census data. As noted above, Minnesota undertook special efforts to gain complete data for its report. Systematic efforts to collect data on these and other factors are required to assess equity of care. Even after data on social risk factors are complete, there will be additional methodological challenges to address related to sampling of small population segments. Questions remain about the relevance of collecting specific information on health literacy, given estimates that the vast majority of patients experience health literacy challenges.

Stratifying existing performance measures may be the next most immediately promising strategy, which can support the research suggested above, as efforts from CMS and states demonstrate. Challenges remain, however, and improving data collection practices will be a necessary precedent step for many organizations—an activity that can be promoted through structural measures.

4. *Develop packages of measures for vulnerable subpopulations.*

Given the increasing demands of measurement, focusing on vulnerable subpopulations may require special incentives or warrant special rewards. One way for providers and organizations to demonstrate their capabilities and skills in serving a vulnerable group would be to report on a package of structure, process and patient experience measures tailored to needs. For example, a package of measures addressing patients with LEP or other communication barriers could include standards related to interpreter and other communication and language assistance services, measures addressing the availability and timeliness of such services and targeted surveys assessing patient experiences. Combining LEP with other functional communication challenges would broaden the population for reporting.

Developing measures that are relevant to different subpopulations can be implemented via voluntary action and by payers. Organizations should have the opportunity to voluntarily implement measures to receive incentives. Alternately, payers can require reporting of measures for organizations that provide care for a diverse population.

5. *Use more detailed measures to “drill down” for QI purposes, and to support performance on integrated measures used for public reporting.*

To mitigate the risk of specific domains losing importance, the use of more detailed, or more focused, measures can allow providers and organizations to drill down for QI purposes. These measures need not be the same as those considered for public reporting—and as such, may not need to meet the same psychometric or other standards that measures used for public reporting must meet. The measures can be used internally to support a provider or organization in targeting specific areas for QI. At the same time, the use of more detailed measures supports performance on integrated measures used for public reporting.

Measures and Methods Need to Be Updated to Address Gaps and Inconsistencies.

Our paper presents a first look at opportunities for integration of health literacy, cultural competence and communication and language assistance. The measure examples are not meant to be exhaustive, but illustrative. It is possible we may have missed some important measures or misclassified others. In addition, there may be better ways to conceptualize the domains common across these concepts. A multi-stakeholder process involving representatives of patients with different cultural perspectives and language

⁶¹Ng, J. H., Ye, F., Ward, L. M., Haffer S. C., Scholle, S. H. (2017) Data on Race, Ethnicity, and Language Largely Incomplete for Managed Care Plan Members. *Health Affairs*. 36(3):548-552.

needs, payers and representatives of different components of the health care system is needed to vet and fully develop these ideas.

Indeed, all our recommendations depend on the active engagement of payers that drive performance through payment incentives. Although CMS has indicated interest in patient-centered care in the National Quality Strategy and in health equity, through its Measure Development Plan drafted to comply with MACRA, the approach to adapting and updating measures needs to create alignment across multiple payers and different levels of the health care system—practices, hospitals, network and health plans. Measurement should be implemented in the context of accountability programs.

The Role of Payers and Policy Makers

Payers and policy makers can spur action by implementing incentives. For example, payers and regulators can begin by incentivizing better data collection, followed by incentivizing stratification and equity-focused QI. By promoting this sequence of steps, payers and policy makers can promote progress toward public accountability for stratified performance measurement and disparities reduction. They can also promote improvement in specific areas by providing incentives for reporting selected measure packages, as described above. Value-based purchasing will be a key level for promoting progress in, and accountability for, meeting the needs of diverse populations.

Conclusion

Although the concepts of health literacy, cultural competence and language access grew out of different movements and historical contexts, they have many common components and address common concerns. The enhanced National CLAS Standards have done much to integrate these concepts by broadening the way we think about language, communication and culture. However, adoption of the standards continues to lag. Patient-centered care, which also shares many domains common across these concepts, may offer a more generally acceptable integrating framework because of its widespread appeal. Many existing measures address these common domains and can be readily implemented through the lens of patient-centered care, yet challenges remain. We suggest a sequence of steps forward to implement measures that will address the cultural and communication needs of an increasingly diverse population.

Exhibits

Exhibit 1 Definitions

Topic	Definition	Author/Date
Health Literacy	The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.	Institute of Medicine (IOM). (2004). <i>Health Literacy: A Prescription to End Confusion</i> .
Language Access	Is achieved when individuals with LEP can communicate effectively with HHS employees and contractors and participate in HHS programs and activities.	U.S. Department of Health and Human Services (DHHS). (2013). <i>Language Access Plan</i> .
Cultural Competence	A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.	U.S. Department of Health and Human Services (DHHS), Office of Minority Health. (2001). <i>National Standards for Culturally and Linguistically Appropriate Services in Health Care</i> .
Communication and Language Assistance	All communication needs and services, e.g., sign language, braille, oral interpretation, and written translation.	U.S. Department of Health and Human Services Office on Minority Health. (2013). <i>National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice</i> .
Patient-Centered	Care that is respectful of and responsive to individual preferences, needs, and values, and ensuring that patient values guide all clinical decisions.	Institute of Medicine, Committee on Quality of Health Care in America. (2001). <i>Crossing the Quality Chasm: A New Health System for the 21st Century</i> .

Exhibit 2 Summary of Evidence for Effective Interventions by Concept

Concept	Evidence
Health Literacy	<ul style="list-style-type: none"> • The Agency for Healthcare Research and Quality’s (AHRQ) Health Literacy Universal Precautions Toolkit provides evidence-based tools to assist in communication with patients (i.e. the Teach-Back method, tools to encourage patients to ask questions, and tools for communicating in non-technical language).⁶² • The National Quality Forum’s (NQF) Preferred Practices for Measuring and Reporting Cultural Competency recommends the use of the tools noted above as well as use of community health workers to help patients understand their disease and self-management activities.⁶³
Communication and Language Assistance	<ul style="list-style-type: none"> • Providing information in writing is associated with improved care.⁶⁴ • Visual aids are associated with better patient adherence among people with limited English proficiency.⁶⁴ • Providing information in patients’ native language may improve adherence.⁶⁵ • Use of trained interpreters may result in improved diagnoses.⁶⁵ • Use of community health workers has been demonstrated to improve outcomes among diabetic patients with language barriers.⁶⁶ • English-speaking patients with functional disabilities such as blindness or hearing loss may require auxiliary aids such as assistive listening devices, video interpretive services, or braille transcription services.⁶⁷
Cultural Competence	<ul style="list-style-type: none"> • NQF has identified common practices effective in reducing disparities including use of community health workers, collaboration across sectors, collection and analysis of data to identify disparities, and implementation of quality improvement activities focused on disparities.⁶⁸ • Culturally tailored, multi-disciplinary team-based interventions that address patients at multiple points in their interaction with the health care system, and interactive patient education and navigation efforts can improve cultural competence and reduce disparities.⁶⁹ • Community health worker interventions and applications can improve care outcomes and help organizations understand values and concerns that may be common in the community.⁷⁰

⁶² Agency for Healthcare Research and Quality. (2016, February). *Health Literacy Measurement Tools (Revised)*. Retrieved from <https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html>

⁶³ National Quality Forum (NQF). (2009). *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report*. Washington, DC: National Quality Forum

⁶⁴ Schillinger, D., Machtinger, E., Wang, F., Chen, L-L., Win, K., Palacios, J., Rodriguez, M., Bindman, A. (2005, February). *Language, Literacy, and Communication Regarding Medication in an Anticoagulation Clinic: Are Pictures Better Than Words?* Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK20494/pdf/Bookshelf_NBK20494.pdf

⁶⁵ Bauer, A., Alegría, M. (2010). *Impact of patient language proficiency and interpreter service use on the quality of psychiatric care: a systematic review*. *Psychiatric Services*, 61(8), 765-773.

⁶⁶ Pottie, K., Hadi, A., Chen, J., Welch, V., Hawthorne, K. (2013, September). Realist review to understand the efficacy of culturally appropriate diabetes education programmes. *Diabetic Medicine*, 30(9): 1017-1025

⁶⁷ National Quality Forum. (2017). *Effective Interventions in Reducing Disparities in Healthcare and Health Outcomes in Selected Conditions. Final Report*. Washington, DC: National Quality Forum.

⁶⁸ National Quality Forum (NQF). (2009). *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report*. Washington, DC: National Quality Forum.

⁶⁹ Chin, M.H., Clarke, A.R., Nocon, R.S., Casey, A.A., Goddu, A.P., Keesecker, N.M., & Cook, S.C. (2012). A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. *Journal of General Internal Medicine*, 27(8), 992-1000.

⁷⁰ Centers for Disease Control and Prevention. (2015, April). *Addressing Chronic Disease through Community Health Workers: A POLICY AND SYSTEMS-LEVEL APPROACH A POLICY BRIEF ON COMMUNITY HEALTH WORKERS*. Retrieved from https://www.cdc.gov/dhdsp/docs/chw_brief.pdf

Patient-Centered Care

- Patient-centered care may impact patient experience and care, effectiveness and safety.⁷¹
 - Physician-patient communication may affect health outcomes both directly (reduction of anxiety) and indirectly (trust leading to improved medication adherence).⁷²
 - The Patient-Centered Medical Home's Impact on Cost and Quality Annual Review of Evidence shows a trend in reductions in utilization and cost among patient-centered medical homes.⁷³
 - The Patient-Centered Primary Care Collaborative report found six of the seven identified peer-reviewed studies showed improved clinical quality on one or more measures and one study showed mixed results.⁷³
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⁷¹ Scholle, S. H., Torda, P., Peikes, D., Han, E., Genevro, J. Engaging Patients and Families in the Medical Home. (Prepared by Mathematica Policy Research under Contract No. HHS2902009000191 TO2.) AHRQ Publication No. 10-0083-EF. Rockville, MD: Agency for Healthcare Research and Quality. June 2010.

⁷² Street, J. L., Makoul, G., Arora, N. K., & Epstein, R. M. (2009). How does communication heal? Pathways linking clinician-patient communication to health outcomes. *Patient Education and Counseling*, 74(3), 295-301.

⁷³ Nielsen, M., Buelt, L., Patel, K., Nichols, L. (2016, February). *The Patient-Centered Medical Home's Impact on Cost and Quality Annual Review of Evidence 2014-2015*. Retrieved from <https://www.pcpcc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality%2C%20Annual%20Review%20of%20Evidence%2C%202014-2015.pdf>

Exhibit 3 Integrated, Patient-Centered Framework

	CLAS Standards	Health Literacy	Language	Patient-Centered Care
Organization culture and values	CLAS Standard 2: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources. ⁷⁴	<ul style="list-style-type: none"> •Provide incentives to encourage employees to use good communication practices.⁷⁵ •Health care system need to be more proactive and take responsibility to meet the needs of the people it serves by reducing the health literacy demands placed on individuals.⁷⁶ 		<ul style="list-style-type: none"> •The patient-centered medical home fosters an environment of trust and respect.⁷⁷ •Patient-centered care includes an interdisciplinary care team, which is led by a qualified provider of the patient’s choice, who guides care in a continuous, accessible, comprehensive and coordinated manner.⁷⁷
Accountability and Quality Improvement	CLAS Standard 10: Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into assessment measurement and	<ul style="list-style-type: none"> •Employ monitoring and accountability for health literacy policies and practices.⁷⁸ 		<ul style="list-style-type: none"> •Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and

⁷⁴ U.S. Department of Health and Human Services, Office of Minority Health. (2013, April). *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*. Retrieved from <https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf>

⁷⁵ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National Action Plan to Improve Health Literacy*. Retrieved from https://health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pdf

⁷⁶ Centers for Disease Control and Prevention. (n.d.). *Welcome to Health Literacy for Public Health Professionals*. Retrieved from at <https://www.cdc.gov/healthliteracy/training/index.html>

⁷⁷ National Partnership for Women and Families, Principles for Patient- and Family-Centered Care: The Medical Home From the Consumer Perspective (2009) as quoted in Scholle S.H., Torda, P., Peikes, D., Han.E., Genevro, J. (2010, June). *Engaging Patients and Families in the Medical Home*. Retrieved from <https://pcmh.ahrq.gov/sites/default/files/attachments/Engaging%20Patients%20and%20Families%20in%20the%20Medical%20Home.pdf>

⁷⁸ Institute of Medicine (IOM). (2004). *Health Literacy: A Prescription to End Confusion*. Washington, DC: The National Academies Press.

	CLAS Standards	Health Literacy	Language	Patient-Centered Care
	<p>continuous quality improvement activities.⁷⁴</p> <p>CLAS Standard 11: Collect and maintain accurate and reliable demographic data, When linked with other data, health and health care organizations can make increased data-informed decisions and improve the quality of care, consistent with quality improvement activities.⁷⁴</p> <p>CLAS Standard 15: Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.⁷⁴</p>			<p>improvement.⁷⁹</p> <ul style="list-style-type: none"> •Patients and families participate in quality improvement activities at the practice level.⁷⁹ •Routinely undertakes efforts to identify and eliminate any disparities in the quality of care received by its patients.⁷⁷
Workforce	<p>CLAS Standard 3: Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.⁷⁴</p> <ul style="list-style-type: none"> •CLAS Standard 4: Educate 	<ul style="list-style-type: none"> •Support changes to improve public health professionals' health literacy skills.⁷⁶ •Professional continuing education programs in health and related fields, •should incorporate health literacy into their curricula 		<ul style="list-style-type: none"> •Training physicians to be more mindful, informative, and empathic transforms their role from one characterized by authority to one that has the goals of partnership, solidarity, empathy, and collaboration.⁸⁰

⁷⁹ American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). (2007, March). *Joint Principles of the Patient-Centered Medical Home*. Retrieved from http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf

⁸⁰ Epstein, R., & Street RL, J. (2011). The values and value of patient-centered care. *Annals Of Family Medicine*, 9(2), 100-103. doi:10.1370/afm.1239

	CLAS Standards	Health Literacy	Language	Patient-Centered Care
	and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. ⁷⁴	and areas of competence. ⁷⁸		
Assessment				
Individual	CLAS Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. ⁷⁴	<ul style="list-style-type: none"> •Health literacy assessment should be a part of healthcare information systems and quality data collection.⁷⁸ •Evaluate the effectiveness of communications.⁷⁶ •Ensure that health information is relevant to the intended users' social and cultural contexts⁸¹ 	<ul style="list-style-type: none"> •Assess the language assistance needs of current and potential customers to inform policy and processes necessary to implement language assistance services that increase access to programs and services for all populations.⁸² 	<ul style="list-style-type: none"> •Collects data on race, ethnicity, sex, primary language, and language services for each patient and records that information in a manner that can be reported and used to plan and respond to the health and language needs of patients in the practice.⁷⁷
Community	CLAS Standard 12: Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. ⁷⁴	<ul style="list-style-type: none"> •Consider the current literacy level of the intended audience, and design messages based on that level.⁷⁶ 	<ul style="list-style-type: none"> •Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic 	

⁸¹ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). *Health Literacy Basics*. Retrieved from <https://health.gov/communication/literacy/quickguide/factsbasic.htm>

⁸² U.S. Department of Health and Human Services. (2013). *Language Access Plan*. Retrieved from <https://www.hhs.gov/sites/default/files/2013-hhs-language-access-plan.pdf?language=en>.

	CLAS Standards	Health Literacy	Language characteristics of the service area. ⁷⁶	Patient-Centered Care
Community Engagement	CLAS Standard 13: Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness. ⁷⁴	<ul style="list-style-type: none"> •Involve representatives from your target audiences in planning, implementing, disseminating, and evaluating health information and services.⁷⁶ •Develop key partnerships to help facilitate change, influence behavior and generate interest in health literacy.⁷⁶ •Develop partnerships with local programs and institutions that improve quality and access to services, strengthen systems, and formulate effective policies. This includes fostering broad, interdisciplinary approaches to health literacy.⁷⁸ 		<ul style="list-style-type: none"> •Relevant stakeholders patients, their families, clinicians, and health systems should be involved in developing a family of measures to capture important aspects of patient-centered care; doing so will also provide an opportunity to align stakeholders' perspectives on what counts as patient-centered care and how it should be accomplished.⁸⁰ •Collaborates with patient and family advisors in quality improvement and practice redesign.⁷⁷

	CLAS Standards	Health Literacy	Language	Patient-Centered Care
<i>Communication</i>	<p>Materials CLAS Standard 8: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.⁷⁴</p>	<ul style="list-style-type: none"> •Present health information in varied forms/ mediums or written in clear, everyday terms so that people can take needed action.⁷⁸ •Use plain language, including key elements^{76,81} •Supplement instructions with pictures.^{81,83} •Make written communication look easy to read.^{81,83} •Improve the usability of information on the Internet.^{81,83} •Consider the communication capacities of the intended users, including those with communication disorders/challenges; tailor communication strategies to their needs and abilities⁸¹ •Consider the current literacy level of the intended audience, and design messages based on that level⁷⁶ •Be sure the materials and messages reflect the age, social and cultural diversity, language, and literacy skills of the intended users. Consider economic contexts, 		

	CLAS Standards	Health Literacy	Language	Patient-Centered Care
		access to services, and life experiences. ^{81,83}		
Oral	<p>CLAS Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.⁷⁴</p> <p>CLAS Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.⁷⁴</p>	<ul style="list-style-type: none"> • •Health practitioners communicate clearly during all interactions with their patients, using everyday vocabulary⁷⁸ •Avoid jargon and explain technical or medical terms.⁸¹ •Ask open-ended questions, instead of those that can be answered with “yes” or “no.”⁸³ •Use the “teach-back” method to ensure that the message is understood and remembered.⁸³ •Ensure health information and services are appropriate, actionable, and easy to understand and use⁷⁶ 		<ul style="list-style-type: none"> •Information and education to facilitate autonomy, self-care and health promotion.⁸² •A more active invitation for involvement.⁸⁰ •Tailored [communication] to patients’ needs to permit meaningful deliberation and shared mind.⁸⁰
Patient Engagement	CLAS Standard 1: Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other	<ul style="list-style-type: none"> •Patients should receive care whenever they need it and in many forms, not just face-to-face visits.⁷⁸ •Provide health information in a manner appropriate to the audience.⁷⁸ 		<ul style="list-style-type: none"> •Acknowledge patients as persons in context of their own social worlds, listened to, informed, respected, and involved in their care—and their wishes are honored (but not mindlessly enacted)⁸⁰ •[Provide] Emotional support

⁸³ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). *Improve the Usability of Health Information*. Retrieved from <https://health.gov/communication/literacy/quickguide/healthinfo.htm>

CLAS Standards	Health Literacy	Language	Patient-Centered Care
communication needs. ⁷⁴	<ul style="list-style-type: none"> • Allow ample time for discussions between patients and healthcare providers.⁷⁸ • Patients feel free and comfortable to ask questions as part of the healing relationship.⁷⁸ 		<p>and alleviation of fear and anxiety.⁸²</p> <ul style="list-style-type: none"> • Caregivers Patient-centered care considers both the art of generalizations and the science of particulars.⁸⁰ • The PCMH “knows” its patients and provides care that is whole-person oriented and consistent with patients’ unique needs and preferences.⁷⁷ • Patients and clinicians are partners in making treatment decisions.⁷⁷

Exhibit 4 Structure Measures

Structure Measures	Domains of Integrated Patient-Centered Framework						
	Organization culture/values	Accountability/QI	Workforce	Community Engagement	Assessment	Communication	Patient engagement
<i>Staff and Patient Surveys</i>							
Communication Climate Assessment Toolkit (C-CAT) ⁸⁴	<ul style="list-style-type: none"> Leadership commitment 	<ul style="list-style-type: none"> Performance evaluations 	<ul style="list-style-type: none"> Workforce development 	<ul style="list-style-type: none"> Community engagement 	<ul style="list-style-type: none"> Information collection 	<ul style="list-style-type: none"> Cross-cultural Communication Language services Health literacy 	<ul style="list-style-type: none"> Individual engagement
<i>Organization Surveys</i>							
Cultural Competency Implementation Measure (RAND) ⁸⁵	<ul style="list-style-type: none"> Leadership Integration into management systems and operations 	<ul style="list-style-type: none"> Data collection, public accountability and quality improvement 	<ul style="list-style-type: none"> Workforce diversity and training 	<ul style="list-style-type: none"> Community engagement 	<ul style="list-style-type: none"> Data collection, public accountability and quality improvement 	<ul style="list-style-type: none"> Patient-provider communication 	<ul style="list-style-type: none"> Care delivery and supporting mechanisms
<i>Accreditation</i>							
Hospital accreditation (Joint Commission) ⁸⁶		<ul style="list-style-type: none"> Use data and information in decision making Set priorities for 	<ul style="list-style-type: none"> Governing bodies conduct orientation regarding safety and quality for the 	<ul style="list-style-type: none"> Leaders involve staff and patients in the design of new or modified services or 	<ul style="list-style-type: none"> The needs of the population served guide decisions about which services will 	<ul style="list-style-type: none"> Provide language interpreting and translation services. Provide 	<ul style="list-style-type: none"> Evaluate the patient's understanding of the education and training

⁸⁴ University of Colorado, Center for Bioethics and Humanities (n.d.). *About C-CAT*. Retrieved from <http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BioethicsHumanities/C-CAT/Pages/About-C-CAT.aspx>

⁸⁵ National Quality Forum. (2012, August 10). *NQF Endorses Healthcare Disparities and Cultural Competency Measures*. Retrieved from http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Healthcare_Disparities_and_Cultural_Competency_Measures.aspx

⁸⁶ The Joint Commission. (2010). *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Retrieved from <http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>

Structure Measures	Domains of Integrated Patient-Centered Framework						
	Organization culture/values	Accountability/QI	Workforce	Community Engagement	Assessment	Communication	Patient engagement
		performance improvement activities and patient health outcomes. • Use the results of data analysis to identify improvement opportunities. • Collect data on the following: patient perception of the safety and quality of care, treatment or services.	population served. • Staff are oriented to cultural diversity based on their individual responsibilities • Staff receives education and training regarding the population served.	processes	be provided • Identify the patient’s oral and written communication needs,	information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient’s needs. • Perform a needs assessment for each patient, including the patient’s cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication • Provide information in a manner tailored to the patient’s age, language, and ability to understand.	provided.

Structure Measures	Domains of Integrated Patient-Centered Framework						
	Organization culture/values	Accountability/ QI	Workforce	Community Engagement	Assessment	Communication	Patient engagement
Health plan accreditation (NCQA) ⁸⁷	<ul style="list-style-type: none"> • QI program description specifies objectives for serving a culturally and linguistically diverse population 	<ul style="list-style-type: none"> • Report selected HEDIS measures • Demonstrate quality improvement • Quality improvement programs include objectives for linguistically diverse and special needs populations. • Member satisfaction is assessed. 	<ul style="list-style-type: none"> • Adjust the providers in its network to meet the cultural and linguistic member needs. 		<ul style="list-style-type: none"> • Assess characteristics and needs of the population including race/ethnicity, cultural health beliefs and practices, preferred languages, health literacy, vision and hearing limitations and other communication needs • Assess the availability of community resources 	<ul style="list-style-type: none"> • Provide notice of member rights, appeals process in culturally and linguistically appropriate manner • Provides communication and language assistance services at no cost for member services, complaints and appeals • Materials (provider directories, QI program information, decisions about grievances and appeals) in easy-to-understand, plain language • 	<ul style="list-style-type: none"> • LTSS care plans include assessment of member goals and preferences, including preferred method of communication, and self-management plan • Patient self-management tools are used

⁸⁷ National Committee for Quality Assurance. (2017). *Patient-Centered Medical Home (PCMH) Recognition*. Retrieved from <http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx>

Structure Measures	Domains of Integrated Patient-Centered Framework						
	Organization culture/values	Accountability/ QI	Workforce	Community Engagement	Assessment	Communication	Patient engagement
						<ul style="list-style-type: none"> • Organization tests directory, and health appraisal, patient self-management tools for ease of use and readability. • Health assessment and patient self-management tools provided in multiple formats: digital, printed, telephone. • Organization provides resources to communicate with those with special visual/hearing needs. 	
Multicultural healthcare distinction	<ul style="list-style-type: none"> • Program description 	<ul style="list-style-type: none"> • Lists measurable 	<ul style="list-style-type: none"> • Uses competent 	<ul style="list-style-type: none"> • Has a process to involve the 	<ul style="list-style-type: none"> • Collects data on 	<ul style="list-style-type: none"> • Translates vital documents into 	

Structure Measures	Domains of Integrated Patient-Centered Framework						
	Organization culture/values	Accountability/ QI	Workforce	Community Engagement	Assessment	Communication	Patient engagement
(NCQA) ⁸⁸	includes objectives for serving a culturally diverse membership	goals for improving CLAS and reducing disparities <ul style="list-style-type: none"> Assesses the use of, and experience with language services Evaluates the effectiveness of interventions to improve CLAS and reduce disparities Reports HEDIS Diversity of Membership measures Analyzes the capacity of the network to meet the cultural and 	interpreter or bilingual services <ul style="list-style-type: none"> Supports practitioners in providing competent language services 	diverse community in QI	race/ethnicity and language needs of individuals and of community	threshold languages <ul style="list-style-type: none"> Provides timely and competent interpreter or bilingual services Collects and publishes information about practitioner languages and language services Supports practitioners in providing language services Provides notice of the availability of language services in appropriate languages 	

⁸⁸ National Committee for Quality Assurance. (2010). Multicultural Health Care Distinction. Retrieved at <http://www.ncqa.org/programs/other-programs/multicultural-health-care-distinction>

Structure Measures	Domains of Integrated Patient-Centered Framework						
	Organization culture/values	Accountability/ QI	Workforce	Community Engagement	Assessment	Communication	Patient engagement
Primary care practices (NCQA Patient-Centered Medical Home 2017) ⁸⁷	<ul style="list-style-type: none"> • Clinician and leadership supports the PCMH model • Communicates and engages patients on the medical home. 	<p>language needs of the membership</p> <ul style="list-style-type: none"> • Identifies disparities in care; implements actions to reduce the disparity; • Stratifies performance data by race and ethnicity or by other indicators (e.g., age, gender, language needs, education, income, type of insurance, disability, health status). • Identify a vulnerable group in their patient population where there is evidence of 	<ul style="list-style-type: none"> • Builds a health-literate organization (e.g., apply universal precautions, provide health literacy training for staff, system redesign to serve patients at different health literacy levels; • Acts to establish processes that address health literacy to improve patient outcomes. • Educates staff on how to interact effectively with people of different 	<ul style="list-style-type: none"> • Involves patients and families in governance and QI • Uses information on the population served by the practice to prioritize needed community resources. • The practice maintains a community resource list by selecting five topics or community service areas of importance to the patient population. • Assesses the usefulness of resources by 	<ul style="list-style-type: none"> • Collects information on how patients identify, e.g., race, ethnicity, and other aspects of diversity such as, gender identity, sexual orientation, religion, occupation, geographic residence. • Documents language needs in its records • Comprehensive health assessment • Demonstrates the ability to assess data and address 	<ul style="list-style-type: none"> • Demonstrates an understanding of the patients’ communication needs • Uses patient-centered methods, such as open-ended questions (i.e., Teach-Back, collaborative method). 	<ul style="list-style-type: none"> • Develops patient care plans for the patients identified for care management. • Works with patients/families/caregivers to incorporate patient preferences and functional lifestyle goals in the care plan. • Addresses barriers • Works with patients/families/ caregivers to develop self-management instructions

Structure Measures	Domains of Integrated Patient-Centered Framework						
	Organization culture/values	Accountability/ QI	Workforce	Community Engagement	Assessment	Communication	Patient engagement
		disparities; <ul style="list-style-type: none"> • Sets goals and acts to improve performance. 	cultures.	requesting and reviewing feedback from patients/families/caregivers about community referrals. <ul style="list-style-type: none"> • Engages with schools or intervention agencies in the community. 	identified gaps using community partnerships, self-management resources or other tools to serve the ongoing needs of its population.		
<i>Program Requirements</i>							
Medicare Merit-Based Incentive Payment System (MIPS) ⁸⁹		<ul style="list-style-type: none"> • Leveraging a QCDR for use of standard questionnaire [for reducing disparities] 		<ul style="list-style-type: none"> • Engagement of community for health status improvement • Practice improvements that engage community resources to support patient health 	<ul style="list-style-type: none"> • Leveraging a QCDR to standardize processes for screening [for social determinants] 	<ul style="list-style-type: none"> • Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities 	<ul style="list-style-type: none"> • Engagement of new Medicaid patients and follow-up • Improved practices that disseminate appropriate self-management materials
Improvement Activities		<ul style="list-style-type: none"> • Implementation of formal quality improvement methods, practice 					

⁸⁹ Centers for Medicare & Medicaid Services (CMS). (n.d.) *Quality Payment Program: Learn About the Program*. Retrieved from <https://qpp.cms.gov/learn/qpp>.

Structure Measures	Domains of Integrated Patient-Centered Framework						
	Organization culture/values	Accountability/ QI	Workforce	Community Engagement	Assessment	Communication	Patient engagement
		changes or other practice improvement processes • Participation in CAHPS or other supplemental questionnaire [like cultural competence]		goals • Regular review practices in place on targeted patient population needs • Use of toolsets or other resources to close healthcare disparities across communities			[address literacy, language] • Leveraging a QCDR to promote use of patient-reported outcome tools • Engagement of patients, family and caregivers in developing a plan of care • Evidenced-based techniques to promote self-management into usual care

Exhibit 5 Process Measures

Target Entity	Measures	Source
Health plan/prescription drug plan	Percent of time that TTY services and foreign language interpretation were available when needed by prospective members who called the plan's prospective enrollee customer service phone number.	CMS Star Ratings ⁹⁰
Hospital	The percentage of limited English proficient patients receiving both initial assessment and discharge instructions supported by interpreters who are assessed and trained or from bilingual providers and bilingual workers/employees assessed for language proficiency.	George Washington University School of Public Health and Health Services ⁹¹
Hospital	The percentage of patient visits and admissions where preferred spoken language for health care is screened and recorded.	George Washington University School of Public Health and Health Services ⁹²
Medical group	Stable coronary artery disease: percentage of patients with stable coronary artery disease who have demonstrated an understanding of how to respond in an acute cardiac event by "teaching back" as to how they would respond in the case of acute cardiac event.	Institute for Clinical Systems Improvement ⁹³

⁹⁰ Centers for Medicare & Medicaid Services (CMS). (n.d.) *Star Ratings*. Retrieved from <https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx>

⁹¹ Agency for Healthcare Research and Quality. (n.d.; a) *Language services: the percent 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*. National Quality Measures Clearinghouse (NQMC). Retrieved from <https://www.qualitymeasures.ahrq.gov/summaries/summary/27296/language-services-the-percent-of-limited-englishproficient-lep-patients-receiving-both-initial-assessment-and-discharge-instructions-supported-by-assessed-and-trained-interpreters-or-from-bilingual-providers-and-bilingual-workersemployees-assessed-for-language>

⁹² Agency for Healthcare Research and Quality. (n.d.; b) *Language services: the percent of patient visits and admissions where preferred spoken language for health care is screened and recorded*. National Quality Measures Clearinghouse (NQMC). Retrieved from <https://www.qualitymeasures.ahrq.gov/summaries/summary/27294/language-services-the-percent-of-patient-visits-and-admissions-where-preferred-spoken-language-for-health-care-is-screened-and-recorded>

⁹³ Agency for Healthcare Research and Quality. (n.d.; c) *Stable coronary artery disease: percentage of patients with stable coronary artery disease who have demonstrated an understanding of how to respond in an acute cardiac event by "teaching back" as to how they would respond in the case of acute cardiac event*. National Quality Measures Clearinghouse (NQMC). Retrieved from <https://www.qualitymeasures.ahrq.gov/summaries/summary/46814/Stable-coronary-artery-disease-percentage-of-patients-with-stable-coronary-artery-disease-who-have-demonstrated-an-understanding-of-how-to-respond-in-an-acute-cardiac-event-by-teaching-back-as-to-how-they-would-respond-in-the-case-of-acute-cardiac-event>

Exhibit 6 Patient Experience Measures ⁹⁴

Topic	Cultural Competence	Health Literacy	Patient-Centered Medical Home
Communication	X	X	X
Medications		X	X
Tests		X	X
Forms		X	
Interpreters	X		
Complementary & Alternative Medicine	X		
Experiences of Discrimination	X		
Trust	X		
Self-Management Support		X	X
Shared Decision-Making			X
Mental Health			X
Provider Knowledge of Specialist Care			X
Access			X

⁹⁴ Agency for Healthcare Research and Quality. (n.d.) Supplemental Items for the CAHPS Clinician & Group Survey. Retrieved from <https://www.ahrq.gov/cahps/surveys-guidance/item-sets/cg/index.html>

Exhibit 7 Examples of Surveys Items Related to Experience of Health Literacy and Cultural Competence⁹⁵

Content	Examples
Common to Health Literacy & Cultural Competence	HL2/CU2. How often did this provider use medical words you did not understand? HL3/CU3. How often did this provider talk too fast when talking with you? HL17/CU8. How often did this provider use a condescending, sarcastic, or rude tone or manner with you?
Health Literacy	HL 4: How often did this provider use pictures, drawings, models, or videos to explain things to you? HL14. How often did this provider ask you to describe how you were going to follow these instructions? HL30. In the last 12 months, how often were you offered help to fill out a form at this provider's office?
Cultural Competence	CU17. In the last 12 months, did you feel you could trust this provider with your medical care? CU20. In the last 12 months, did you feel this provider really cared about you as a person? CU14. In the last 12 months, how often have you been treated unfairly at this provider's office because of your race or ethnicity? CU24. In the last 12 months, how often were you treated unfairly at this provider's office because you did not speak English very well? 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? CU26. In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge? CU32. Did any of your appointments start late because you had to wait for an interpreter?

⁹⁵ Agency for Healthcare Research and Quality. (n.d.) Supplemental Items for the CAHPS Clinician & Group Survey. Retrieved from <https://www.ahrq.gov/cahps/surveys-guidance/item-sets/cg/index.html>