



## Measure Information

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

### Brief Measure Information

**NQF #: 1902**

#### Corresponding Measures:

**De.2. Measure Title:** Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy

**Co.1.1. Measure Steward:** Agency for Healthcare Research and Quality

**De.3. Brief Description of Measure:** These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician & Group Survey. The item set includes the following domains: Communication with Provider (Doctor), Disease Self-Management, Communication about Medicines, Communication about Test Results, and Communication about Forms. Samples for the survey are drawn from adults who have had at least one provider's visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the core Clinician/Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifiers). Two composites can be calculated from the item set: 1) Communication to improve health literacy (5 items), and 2) Communication about medicines (3 items)

**1b.1. Developer Rationale:** The Item Set for Addressing Health Literacy was developed to provide health care providers with data that could help them improve their health literacy practices. The survey can be used to:

- Identify specific topic areas for quality improvement (e.g., communication about test results, medications, and forms).
- Recognize particular behaviors that inhibit effective communication (e.g., talking too fast, using medical jargon).
- Assist in designing a safer, shame-free environment where patients feel comfortable discussing their health care concerns (e.g., showing interest in questions, explaining forms).
- Measure the effect of behaviors that promote effective communication (e.g., confirming understanding through teach-back, using visual aids).

For example, providers could administer the CAHPS Item Set for Addressing Health Literacy as an assessment tool to identify their health literacy strengths and weaknesses. Having identified opportunities for improvement and embarked on quality improvement activities, the providers could use the Item Set for Addressing Health Literacy again to evaluate the success of its improvement activities.

To assist providers in determining how to address an area needing improvement, the Agency for Healthcare Research and Quality (AHRQ) has mapped each item in the Item Set for Addressing Health Literacy to a health literacy practice recommended by the American Medical Association (AMA) Foundation and the AMA in their 2007 monograph Health Literacy and Patient Safety: Help Patients Understand. This Health Literacy Quality Improvement Crosswalk is available in Appendix B of the About the CAHPS Item Set for Addressing Health Literacy, available at: [https://www.cahps.ahrq.gov/Surveys-Guidance/Item-Sets/~media/Files/SurveyDocuments/CG/12%20Month/Get\\_Surveys/1311\\_about\\_health\\_lit.pdf](https://www.cahps.ahrq.gov/Surveys-Guidance/Item-Sets/~media/Files/SurveyDocuments/CG/12%20Month/Get_Surveys/1311_about_health_lit.pdf). This crosswalk can also identify items to evaluate the implementation of particular AMA recommendations. For specific techniques and strategies to facilitate AMA recommendations, please refer to the monograph at [http://www.ama-assn.org/ama1/pub/upload/mm/367/hl\\_monograph.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/367/hl_monograph.pdf).

Finally, patients can use information from the measures to help make better and more informed choices about their health care.

**S.4. Numerator Statement:** We recommend that the Clinicians/Groups' Health Literacy Practices measures be calculated using the top box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses.

Two composites can be calculated from the item set: 1) Communication to improve health literacy (5 items), and 2) Communication about medicines (3 items)

**S.7. Denominator Statement:** Adults with a visit to the provider for which the survey is being fielded within the last 12 months who responded to the item.

**S.10. Denominator Exclusions:** Exclusions are made when sample is drawn from provider records. Only patients 18 or older and those who have had a visit with a provider in the last 12 months are sampled. Core question 4 verifies that the respondent got care from the provider in the last 12 months.

**De.1. Measure Type:** Outcome

**S.23. Data Source:** Instrument-Based Data

**S.26. Level of Analysis:** Clinician : Group/Practice, Clinician : Individual

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

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

1903:CAHPS Item Set for Addressing Health Literacy

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

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

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

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

### 1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

1902\_Evidence\_MSF5.0\_Data.doc

### 1b. Performance Gap

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

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

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

The Item Set for Addressing Health Literacy was developed to provide health care providers with data that could help them improve their health literacy practices. The survey can be used to:

- Identify specific topic areas for quality improvement (e.g., communication about test results, medications, and forms).
- Recognize particular behaviors that inhibit effective communication (e.g., talking too fast, using medical jargon).
- Assist in designing a safer, shame-free environment where patients feel comfortable discussing their health care concerns (e.g., showing interest in questions, explaining forms).
- Measure the effect of behaviors that promote effective communication (e.g., confirming understanding through teach-back, using visual aids).

For example, providers could administer the CAHPS Item Set for Addressing Health Literacy as an assessment tool to identify their health literacy strengths and weaknesses. Having identified opportunities for improvement and embarked on quality improvement activities, the providers could use the Item Set for Addressing Health Literacy again to evaluate the success of its improvement activities.

To assist providers in determining how to address an area needing improvement, the Agency for Healthcare Research and Quality (AHRQ) has mapped each item in the Item Set for Addressing Health Literacy to a health literacy practice recommended by the American Medical Association (AMA) Foundation and the AMA in their 2007 monograph Health Literacy and Patient Safety: Help Patients Understand. This Health Literacy Quality Improvement Crosswalk is available in Appendix B of the About the CAHPS Item Set for Addressing Health Literacy, available at: <https://www.cahps.ahrq.gov/Surveys-Guidance/Item->

Sets/~/media/Files/SurveyDocuments/CG/12%20Month/Get\_Surveys/1311\_about\_health\_lit.pdf. This crosswalk can also identify items to evaluate the implementation of particular AMA recommendations. For specific techniques and strategies to facilitate AMA recommendations, please refer to the monograph at [http://www.ama-assn.org/ama1/pub/upload/mm/367/hl\\_monograph.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/367/hl_monograph.pdf).

Finally, patients can use information from the measures to help make better and more informed choices about their health care.

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

Research indicates that there is substantial room to improve performance across the domains measured by the CAHPS Item Set for Addressing Health Literacy. Almost 8% of patients report that providers sometimes or never explained things in a way they could understand.(1) Patients with limited health literacy report having lower-quality communication with health professionals. They express confusion regarding medical terminology and say that they have insufficient time to express concerns and fail to receive clear explanations.(2-5) The Joint Commission finds that “the safety of patients cannot be assured without mitigating the negative effects of low health literacy and ineffective communications on patient care.”(6) Although using techniques to address patients’ limited health literacy can improve the quality of health care and health outcomes, clinicians employ them infrequently.(7-8)

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

1. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. 2010 National Healthcare Disparities Report. AHRQ Publication No. 11-0005. Agency for Healthcare Research and Quality: Rockville, MD, March 2011.
2. Makaryus AN, Friedman EA. Patients’ understanding of their treatment plans and diagnosis at discharge. *Mayo Clin Proc.* 2005;80(8):991–4.
3. Kripalani S, Jacobson TA, Mugalla IC, Cawthon CR, Niesner KJ, Vaccarino V. Health literacy and the quality of physician-patient communication during hospitalization. *J Hosp Med.* 2010;5(5):269–75.
4. Schillinger D, Bindman A, Wang F, Stewart A, Piette J. Functional health literacy and the quality of physician-patient communication among diabetes patients. *Patient Educ Couns.* 2004;52(3):315–23.
5. Kripalani S, Henderson LE, Jacobson TA, Vaccarino V. Medication use among inner-city patients after hospital discharge: patient-reported barriers and solutions. *Mayo Clin Proc.* 2008;83(5):529–35.
6. Joint Commission. What did the doctor say? Improving health literacy to protect patient safety. Oakbrook Terrace (IL): Joint Commission; 2007. p. 5.
7. Schillinger D, Piette J, Grumbach K, Wang F, Wilson C, Daher C, et al. Closing the loop: physician communication with diabetic patients who have low health literacy. *Arch Intern Med.* 2003;163(1):83–90.
8. Schwartzberg JG, Cowett A, VanGeest J, Wolf MS. Communication techniques for patients with low health literacy: a survey of physicians, nurses, and pharmacists. *Am J Health Behav.* 2007;31(Suppl 1):S96–104.

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

Racial and ethnic disparities in patient reports of provider communication have been documented.The 2010 National Healthcare Disparities Report (NHDR) tracked patient-provider communication from 2002-2007. It found:

- Between 2002 and 2007, the percentage of White, middle-income, and high-income adults who reported poor communication with their health providers significantly decreased.
- In all years, Hispanics were significantly more likely than non-Hispanic Whites to report poor communication.

- In 4 of 6 years, Black patients were more likely than Whites to report poor communication with health providers; the exceptions were 2006 and 2007.
- In 5 of 6 years, Asians were more likely than Whites to report poor communication; the exception was 2007.

The 2010 NHDR also reported on data from the California Health Interview Survey on patients' understanding of written information from their doctors office. In 2007 Hispanic and non-White patients living in California were less likely than non-Hispanic, White patients to find it easy to understand information from a doctor's office. Also in 2007, patients living in California who did not speak English well or at all were less likely than patients who speak English only or patients who speak English well or very well to find it easy to understand information from a doctor's office. According to the 2005 California Health Interview Survey, 10% of Latino asthmatics reported that had a hard time understanding their doctor, compared to 3% of non-Hispanic Whites. Californian asthmatics with limited English proficiency were also more likely to report problems than native English speakers or asthmatics that speak English very well (13% versus 3% and 4% respectively). Those adults who had problems understanding their doctors were more likely than those who had no problems to visit the ED/urgent care for asthma care (23% v. 13%) and were less likely to have an asthma management plan (27% v. 38%).

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

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

Babey SH, Meng YY, and Jones M. Many Californians with Asthma Have Problems Understanding Their Doctor. Los Angeles, CA: UCLA Center for Health Policy Research, 2009.

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

The measure addresses:

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

**1c.1. Demonstrated high priority aspect of healthcare**

Affects large numbers, Patient/societal consequences of poor quality

**1c.2. If Other:**

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

**List citations in 1c.4.**

Health literacy is "the degree to which an individual has the capacity to obtain, process, and understand health information and services in order to make appropriate health decisions." (1) It is estimated that only 12 percent of U.S. adults have proficient health literacy. (2) Over a third of U.S. adults—77 million people—have difficulty with common health tasks, such as following directions on a prescription drug label or adhering to a childhood immunization schedule using a standard chart. (3)

The complexity of health information and the communication skills of health professionals affect health literacy. (4,5) Improving health literacy is a national health priority issue (6,7) and health literacy objectives are included in Healthy People 2010. (8) In 2003 the Institute of Medicine identified health literacy as a cross-cutting health care priority, (9) the American Medical Association published a video and manual to instruct clinicians on how to improve their health literacy practices, (10) and the U.S. Department of Health and Human Services established a Health Literacy Work Group. In 2004 two landmark reports were published: the Institute of Medicine's "Health Literacy: A Prescription to End Confusion" (11) and the Agency for Healthcare Research and Quality's "Literacy and Health Outcomes." (12)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Clinician and Group survey includes an item that asks, "How often does your doctor explain things in a way that was easy to understand?" However, responses to this item do not indicate which aspects of communication are problematic or how clinicians and their practices can improve the quality of their communications. The CAHPS Item Set for Addressing Health Literacy was developed as as both a measure of whether health care

professionals have succeeded in reducing the health literacy demands they place on patients, and as a tool for quality improvement.

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

1. Ratzan SC, Parker RM. Introduction. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services; 2000. Report No.: NLM Pub. No. CBM 200-1.
2. Kutner M, Greenberg E, Jin Y, Paulsen C. The health literacy of America's adults: results from the 2003 National Assessment of Adult Literacy. Washington DC: National Center for Educational Statistics; 2006.
3. U. S. Department of Health and Human Services. America's health literacy: why we need accessible health information. Rockville, MD: U. S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion; 2009.
4. U.S. Department of Health and Human Services. Communicating health: priorities and strategies for progress. Washington DC; 2003 July.
5. Baker DW. The meaning and the measure of health literacy. J Gen Intern Med. 2006 Aug;21(8):878-83.
6. Parker R, Ratzan SC. Health literacy: a second decade of distinction for Americans. Journal of health communication. [Historical Article]. 2010;15 Suppl 2:20-33.
7. Koh H, Berwick D, Clancy C, Baur C, Brach C, Harris L, Zerhusen E. New federal policy initiatives to boost health literacy can help the nation move beyond the cycle of costly 'crisis care.' Health Affairs. 2012. 31(2): epublished before print.
8. U.S. Department of Health and Human Services. Healthy people 2010: understanding and improving health. 2nd ed: U.S. Government Printing Office; 2000.
9. Adams K, Corrigan JM. Priority areas for national action: transforming health care quality. Washington DC: The National Academies Press; 2003.
10. Weiss BD. Health literacy: a manual for clinicians. Chicago: American Medical Association Foundation and American Medical Association; 2003.
11. Institute of Medicine. Health literacy: a prescription to end confusion. Washington, DC: The National Academies Press; 2004.
12. Berkman ND, DeWalt DA, Pignone MP, Sheridan SL, Lohr KN, Lux L, et al. Literacy and health outcomes. Rockville, MD: Agency for Healthcare Research and Quality; 2004.

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

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

**De.6. Non-Condition Specific** (check all the areas that apply):

Disparities Sensitive, Person-and Family-Centered Care, Safety : Medication

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

<https://www.cahps.ahrq.gov/Surveys-Guidance/Item-Sets/Health-Literacy.aspx>

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

the specifications)

**Attachment:**

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

**Attachment:**

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

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

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

We recommend that the Clinicians/Groups' Health Literacy Practices measures be calculated using the top box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses.

Two composites can be calculated from the item set: 1) Communication to improve health literacy (5 items), and 2) Communication about medicines (3 items)

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

Last 12 months.

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

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

Top Box Method: Calculate the number of responses in the most positive response category for each item. Below each item is listed with the most positive response for the item in parentheses.

Note that for HL1, HL2, HL3, HL5, HL6, and HL17 the most positive response is "Never." Specific instructions for how reverse coding can be done in SAS can be found in "Instructions for Analyzing CAHPS Data" (available at: [https://www.cahps.ahrq.gov/Surveys-Guidance/Dental/~media/Files/SurveyDocuments/Dental/Prep\\_Analyze/2015\\_instructions\\_for\\_analyzing\\_data.pdf](https://www.cahps.ahrq.gov/Surveys-Guidance/Dental/~media/Files/SurveyDocuments/Dental/Prep_Analyze/2015_instructions_for_analyzing_data.pdf)) in the section called "Data Set Specification."

HL1 In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English? (Never)

HL2 In the last 12 months, how often did this provider use medical words you did not understand? (Never)

HL3 In the last 12 months, how often did this provider talk too fast when talking with you? (Always)

HL4 In the last 12 months, how often did this provider use pictures, drawings, models, or videos to explain things to you? (Always)

HL5 In the last 12 months, how often did this provider ignore what you told him or her? (Never)

HL6 In the last 12 months, how often did this provider interrupt you when you were talking? (Never)

HL7 In the last 12 months, how often did this provider show interest in your questions and concerns? (Always)

- HL8 In the last 12 months, how often did this provider answer all your questions to your satisfaction? (Always)
- HL9 In the last 12 months, how often did this provider give you all the information you wanted about your health? (Always)
- HL10 In the last 12 months, how often did this provider encourage you to talk about all your health questions or concerns? (Always)
- HL11 In the last 12 months, did you see this provider for a specific illness or for any health condition? [screener for HL 12-17] (NA)
- HL12 In the last 12 months, did this provider give you instructions about what to do to take care of this illness or health condition (Yes)
- HL13 In the last 12 months, how often were these instructions easy to understand? (Always)
- HL14 In the last 12 months, how often did this provider ask you to describe how you were going to follow these instructions? (Always)
- HL15 Sometimes providers give instructions that are hard to follow. In the last 12 months, how often did this provider ask you whether you would have any problems doing what you need to do to take care of this illness or health condition? (Always)
- HL16 In the last 12 months, how often did this provider explain what to do if this illness or health condition got worse or came back? (Always)
- HL17 In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Never)
- HL18 In the last 12 months, did this provider prescribe any new medicines or change how much medicine you should take? [screener for HL19-25] (NA)
- HL19 In the last 12 months, did this provider give instructions about how to take your medicines? (Yes)
- HL20 In the last 12 months, how often were these instructions about how to take you medicines easy to understand? (Always)
- HL21 In the last 12 months, did this provider explain the possible side effects of your medicines? (Yes)
- HL22 In the last 12 months, how often were these explanations was easy to understand? (Always)
- HL23 In the last 12 months, other than a prescription, did this provider give you written information or write down information about how to take your medicines? (Yes)
- HL24 In the last 12 months, how often was the written information you were given easy to understand? (Always)
- HL25 In the last 12 months, how often did this provider suggest ways to help you remember to take your medicines? (Always)
- Core 21 In the last 12 months, did this provider order a blood test, x-ray, or other test for you? [screener for Core 22] (NA)
- Core 22 In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?(NA) [screener for HL26]
- HL26 In the last 12 months, how often were the results of your blood test, x-ray, or other test easy to understand? (Always)
- HL27 In the last 12 months, did you sign any forms at this provider's office [screener for HL28] (NA)



HL28 In the last 12 months, how often did someone explain the purpose of a form before you signed it? (Always)

HL29 In the last 12 months, did you fill out any forms at this provider's office? [screener for HL30-31] (NA)

HL30 In the last 12 months, how often were you offered help to fill out a form at this provider's office? (Always)

HL31 In the last 12 months, how often were the forms from this provider's office easy to fill out? (Always)

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

Adults with a visit to the provider for which the survey is being fielded within the last 12 months who responded to the item.

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

Elderly

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

The denominator is the total number of respondents who selected a response option to a particular item. Respondents may have not answered an item because of a screener that skipped them over that item, or because they chose to skip that question.

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

Exclusions are made when sample is drawn from provider records. Only patients 18 or older and those who have had a visit with a provider in the last 12 months are sampled. Core question 4 verifies that the respondent got care from the provider in the last 12 months.

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

Exclusions are made when sample is drawn from provider records. Only patients 18 or older and those who have had a visit with a provider in the last 12 months are sampled. Core question 4 verifies that the respondent got care from the provider in the last 12 months.

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

Stratification by race, ethnicity and education can be done using the following Core Items:

30: What is the highest grade or level of school that you have completed? (6 responses)

31: Are you of Hispanic or Latino origin or descent? (2 responses)

32: What is your race? Mark one or more. (6 responses)

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

No risk adjustment or risk stratification

If other:

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

not applicable.

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

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



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

**S.16. Type of score:**

Non-weighted score/composite/scale

If other:

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

Better quality = Higher score

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

Composites can be calculated for an individual provider (e.g., a doctor), or for a practice or clinic.

The Communication to Improve Health Literacy Composite consists of 5 items:

HL9. In the last 12 months, how often did this provider give you all the information you wanted about your health? (Response: Never/Sometimes/Usually/Always)

HL10. In the last 12 months, how often did this provider encourage you to talk about all your health problems or concerns? (Response: N/S/U/A)

HL14. In the last 12 months, how often did this doctor ask you to describe how you were going to follow these instructions? (Response: N/S/U/A)

HL20. In the last 12 months, how often were these instructions about how to take your medicines easy to understand? (Response: N/S/U/A)

HL26. In the last 12 months, how often were the results of your blood test, x-ray or other test easy to understand? (Response: N/S/U/A)

The Communication about Medicines Composite consists of 3 items:

HL22. In the last 12 months, how often were these explanations [of possible side effects of your medicines] easy to understand? (Response: N/S/U/A)

HL24. In the last 12 months, how often was the written information you were given easy to understand? (Response: N/S/U/A)

HL25. In the last 12 months, how often did this provider suggest ways to help you remember to take your medicines? (Response: N/S/U/A)

To calculate the Communication to Improve Health Literacy Composite:

STEP1: Calculate the proportion of respondents in each response category for each item in the composite (i.e., the number of respondents who gave the response divided by the total number of respondents who answered that item). Start by calculating for HL9:

- The proportion of respondents who answered "never"
- The proportion of respondents who answered "sometimes"

- The proportion of respondents who answered “usually”
- The proportion of respondent who answered “always”

Follow this step for HL10, HL14, HL20, and HL26.

STEP 2: Calculate the average proportion responding to each category across the questions in the composite. For example, to calculate the composite for those who answered “always,” calculate:

(Proportion of respondents who answered “always” to HL9 + Proportion of respondents who answered “always” to HL10 + Proportion of respondents who answered “always” to HL14 + Proportion of respondents who answered “always” to HL20 + Proportion of respondents who answered “always” to HL26)/5

The Communication about Medicines Composite is calculated in the same way, except that – because there are only 3 items in the composite, the denominator in the calculation of the average proportion responding to each category should be divided by 3.

Additional detail on the algorithm to calculate these composites is available from the CAHPS® Clinician & Group Surveys Instructions for Patient Experience Measures. Instructions for analyzing composite measures in SAS are available in the CAHPS Clinician & Group Surveys and Instructions, Instructions for Analyzing Data. Both are available at: <https://www.cahps.ahrq.gov/Surveys-Guidance/CG/Get-CG-Surveys-and-Instructions.aspx>.

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

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

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

Details on sampling methodology can be found at [https://www.cahps.ahrq.gov/Surveys-Guidance/CG/~media/Files/SurveyDocuments/CG/12%20Month/Admin\\_Survey/1033\\_CG\\_Fielding\\_the\\_Survey.pdf](https://www.cahps.ahrq.gov/Surveys-Guidance/CG/~media/Files/SurveyDocuments/CG/12%20Month/Admin_Survey/1033_CG_Fielding_the_Survey.pdf)

**Data Source:** The source of sample information will vary by survey sponsor. The decision will depend on which organization has the most accurate and complete data. Health plans or purchasers of care may have administrative or billing data to identify individual patients. In some instances, the data to identify individual patients may be found only in the records of medical practices. It may be necessary to pull data from two or more sources in order to have both up-to-date contact information and to be able to connect the visit to a specific provider.

**Number Completes and Response Rates:** 45 completed surveys per provider is recommended for measures of individual providers. 300 completed surveys are recommended for large entities such as multi-site medical practices. Surveys can be administered by mail, by phone, or mail with phone follow-up. Response rates of at least 40% are recommended.

**Administration Mode.** The CAHPS Item Set for Health Literacy may be administered by one of the following modes as each has been found to provide comparable results:

- Mail only: Three-wave mail protocol: complete survey and letter, postcard reminder (10 days later), complete survey (3 weeks later).
- Telephone only: At least 6 attempts on different days (weekdays and weekends), at different times of the day, and in different weeks.
- Mail with telephone follow up: mail protocol followed by telephone protocol 3 weeks after sending the second questionnaire.

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

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

<p><b>S.22. Missing data</b> (specify how missing data are handled, e.g., imputation, delete case.)  <u>Required for Composites and PRO-PMs.</u></p>
<p><b>S.23. Data Source</b> (Check <i>ONLY</i> the sources for which the measure is SPECIFIED AND TESTED).          If other, please describe in S.24.  <a href="#">Instrument-Based Data</a></p> <p><b>S.24. Data Source or Collection Instrument</b> (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)          IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.  <a href="#">CAHPS Item Set for Addressing Health Literacy</a></p> <p><b>S.25. Data Source or Collection Instrument</b> (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)</p> <p><b>S.26. Level of Analysis</b> (Check <i>ONLY</i> the levels of analysis for which the measure is SPECIFIED AND TESTED)  <a href="#">Clinician : Group/Practice, Clinician : Individual</a></p> <p><b>S.27. Care Setting</b> (Check <i>ONLY</i> the settings for which the measure is SPECIFIED AND TESTED)  <a href="#">Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office</a>          If other:</p> <p><b>S.28. COMPOSITE Performance Measure</b> - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)</p>
<p><b>2a. Reliability</b> – See attached Measure Testing Submission Form</p> <p><b>2b. Validity</b> – See attached Measure Testing Submission Form  <a href="#">1902_MeasureTesting_MS5.0_Data.doc</a></p>

<p><b>3. Feasibility</b></p>
<p>Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.</p>
<p><b>3a. Byproduct of Care Processes</b>          For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).</p> <p><b>3a.1. Data Elements Generated as Byproduct of Care Processes.</b>  <a href="#">Other</a>          If other: <a href="#">Survey of patients</a></p>
<p><b>3b. Electronic Sources</b>          The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.</p> <p><b>3b.1. To what extent are the specified data elements available electronically in defined fields?</b> (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)  <a href="#">No data elements are in defined fields in electronic sources</a></p> <p><b>3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.</b></p>

Surveys could be administered through a Web portal that would calculate scores automatically. For example, items could be put on Survey Monkey. However, respondents would be restricted to those who had access to the Internet and skills to navigate the survey online. This would like bias the sample unless there was mail and/or phone follow-up.

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

**Attachment:**

### 3c. Data Collection Strategy

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

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

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

To maximize response rates among Spanish speakers, respondents identified as Spanish-speaking in the sample file were mailed materials in both English and Spanish. Respondents were mailed an advance notification letter letting them know about the survey. The survey was mailed with a cover letter from RAND approximately one week after the advance notification letter was mailed out. The cover letter provided basic information about the purpose of the survey, the confidentiality of the information provided, and how the data would be used. To evaluate the effect of sending a reminder letter, we conducted an experiment whereby half of the respondents were randomly selected to receive a reminder letter two weeks after the initial mailing of the survey. Two weeks after mailing the reminder letter, non-respondents were mailed a second copy of the survey with another reminder letter. Two weeks after mailing the second copy of the survey, non-respondents were routed to a phone center for phone follow up where multiple attempts at different times of the day were made to complete the survey by phone. Respondents who completed and returned the survey or completed the survey by telephone were mailed a thank you-letter.

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

## 4. Usability and Use

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

### 4a. Accountability and Transparency

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

#### 4.1. Current and Planned Use

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

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

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

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

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

**4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement.** (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

**4b. Improvement**

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

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

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

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

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

**4c. Unintended Consequences**

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

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

Errors can occur when coding. Instructions for cleaning and analysis can be found in the Instructions for Analyzing Data from CAHPS Surveys, available at: [https://www.cahps.ahrq.gov/Surveys-Guidance/Dental/~media/Files/SurveyDocuments/Dental/Prep\\_Analyze/2015\\_instructions\\_for\\_analyzing\\_data.pdf](https://www.cahps.ahrq.gov/Surveys-Guidance/Dental/~media/Files/SurveyDocuments/Dental/Prep_Analyze/2015_instructions_for_analyzing_data.pdf)

**5. Comparison to Related or Competing Measures**

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

**5. Relation to Other NQF-endorsed Measures**

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually

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

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

0005 : CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 -Adult, Child

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

**5a. Harmonization**

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

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

**Are the measure specifications completely harmonized?**

Yes

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

**5b. Competing Measures**

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

**OR**

Multiple measures are justified.

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

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

not applicable.

## Appendix

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

**Attachment:**

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** Agency for Healthcare Research and Quality

**Co.2 Point of Contact:** Pamela, Owens, Pam.Owens@ahrq.hhs.gov, 301-427-1412-

**Co.3 Measure Developer if different from Measure Steward:** Agency for Healthcare Research and Quality

**Co.4 Point of Contact:** Cindy, Brach, cindy.brach@ahrq.hhs.gov, 301-427-1444-

## Additional Information

**Ad.1 Workgroup/Expert Panel involved in measure development**

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

Beverly Weidmer, RAND

#1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy, Last  
Updated: Mar 16, 2016

<a href="#">Cindy Brach, AHRQ</a> <a href="#">Ron Hays RAND/UCLA</a>
<b>Measure Developer/Steward Updates and Ongoing Maintenance</b> <b>Ad.2</b> Year the measure was first released: <a href="#">2009</a> <b>Ad.3</b> Month and Year of most recent revision: <a href="#">01, 2012</a> <b>Ad.4</b> What is your frequency for review/update of this measure? <a href="#">No regular schedule</a> <b>Ad.5</b> When is the next scheduled review/update for this measure?
<b>Ad.6</b> Copyright statement: <a href="#">The CAHPS Item Set for Addressing Health Literacy is in the public domain.</a> <b>Ad.7</b> Disclaimers:
<b>Ad.8</b> Additional Information/Comments: