



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 #: 1904

Corresponding Measures:

De.2. Measure Title: Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set

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

De.3. Brief Description of Measure: These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey that includes the following domains: Patient-provider communication; Complementary and alternative medicine; Experiences of discrimination due to race/ethnicity, insurance, or language; Experiences leading to trust or distrust, including level of trust, caring and confidence in the truthfulness of their provide; and Linguistic competency (Access to language services). Samples for the survey are drawn from adults who have at least one provider's visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the Core Clinician/Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifiers). Two composites can be calculated from the item set: 1) Providers are caring and inspire trust (5 items), and 2) Providers are polite and considerate (3 items).

1b.1. Developer Rationale: Organizations that field the CAHPS Clinician & Group Survey may want to use this item set to inform consumers, to provide feedback to providers, and to spur improvements in patients' experiences. Health care organizations using this item set can use the composite measures for benchmarking and reporting at the group level. For example, a health system may report the composite measures listed above to compare performance across provider groups.

At the level of individual providers, health care organizations may want to share item-level scores in order to help providers better understand the behaviors that promote effective communication with a diverse patient population, such as minimizing negative communication behaviors (e.g., interrupting patients, talking too fast). This item set is intended to generate data that health care providers can use to improve their cultural competence by:

- Identifying specific topic areas for quality improvement.
- Recognizing particular behaviors that inhibit effective communication.
- Measuring the effect of behaviors that promote effective communication.

Providers can identify their strengths and weaknesses by topic area as well as for individual items by conducting different kinds of analyses. These analyses can help them understand how their performance on the composite measures and individual items compares to that of other providers; assess the extent to which survey responses differ by the race, ethnicity, or language of respondents; and determine which topics are driving performance on the overall rating measure. For example, analyses of data from the field test pointed to three domains that were highly correlated with the overall ratings for providers:

- Provider are polite and considerate (composite measure)
- Providers are caring and inspire trust (composite measure)
- Equitable treatment (individual items)

Having identified opportunities for improvement and embarked on quality improvement activities, the providers can then field the items again to evaluate the success of improvement activities.

In addition, 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' Cultural Competence measures be calculated using the top box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses.

Two composites can be calculated from the item set: 1) Providers are caring and inspire trust (5 items), and 2) Providers are polite and considerate (3 items).

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:

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
1904_Evidence_MSF5.0_Data.doc

1b. Performance Gap

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

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

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

Organizations that field the CAHPS Clinician & Group Survey may want to use this item set to inform consumers, to provide feedback to providers, and to spur improvements in patients' experiences. Health care organizations using this item set can use the composite measures for benchmarking and reporting at the group level. For example, a health system may report the composite measures listed above to compare performance across provider groups.

At the level of individual providers, health care organizations may want to share item-level scores in order to help providers better understand the behaviors that promote effective communication with a diverse patient population, such as minimizing negative communication behaviors (e.g., interrupting patients, talking too fast). This item set is intended to generate data that health care providers can use to improve their cultural competence by:

- Identifying specific topic areas for quality improvement.
- Recognizing particular behaviors that inhibit effective communication.
- Measuring the effect of behaviors that promote effective communication.

Providers can identify their strengths and weaknesses by topic area as well as for individual items by conducting different kinds of analyses. These analyses can help them understand how their performance on the composite measures and individual items compares to that of other providers; assess the extent to which survey responses differ by the race, ethnicity, or language of respondents; and determine which topics are driving performance on the overall rating measure. For example, analyses of data from the field test pointed to three domains that were highly correlated with the overall ratings for providers:

- Provider are polite and considerate (composite measure)
- Providers are caring and inspire trust (composite measure)
- Equitable treatment (individual items)

Having identified opportunities for improvement and embarked on quality improvement activities, the providers can then field the items again to evaluate the success of improvement activities.
In addition, 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.*

The U.S. Department of Health and Human Services (HHS) has long recognized the importance of ensuring quality and safety through the provision of culturally and linguistically appropriate care. In 2000, the Office of Minority Health (OMH) promulgated the National Standards for Culturally and Linguistically Appropriate Standards in Health Care. Over a decade later, OMH has launched the National CLAS Standards Enhancement Initiative in recognition of both the advancements in cultural competence of the past decade and the need to assist individuals and organizations in the implementation of the National CLAS Standards because many organizations have not made much progress. The enhanced National CLAS Standards, scheduled for release in March 2012, is subtitled, "A Blueprint for Advancing and Sustaining CLAS Practice and Policy."⁽¹⁾ It contains relevant, practical and up-to-date guidance and materials for individuals and organizations seeking to apply the National CLAS Standards.

An example of where performance comes up short is in the provision of language assistance. Approximately 13% of individuals with limited English proficiency and had a usual source of care did not receive language assistance. ⁽²⁾ For non-Hispanics, however, that percentage increased to 36%. Furthermore, only 50% of individuals with limited English proficiency (compared with 85% overall) did not have a usual source of care,⁽²⁾ suggesting that language barriers may inhibit access to care. Other performance gaps are evident in CAHPS benchmarking data, which shows that between only 59 and 76 of Medicaid beneficiaries (depending on the state) reported that their clinicians always exhibited good communication practices such as explaining things clearly and listening to what they had to say.⁽²⁾

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, Office of Minority Health. Forthcoming March 2012. National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Practice and Policy.
2. 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.

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.*

A 2001 Commonwealth Fund survey found that African Americans, Asian Americans, and Hispanics are more likely than Whites to experience difficulty communicating with their physician, to feel that they are treated with disrespect when receiving care, and to feel they would receive better care if they were of a different race or ethnicity.⁽¹⁾ Numerous studies have shown that that minority Americans are more likely to perceive discrimination and report mistrust of health care providers, leading to less satisfaction with their health care. ^(2-6.)

Studies using the National Consumer Assessments of Healthcare Providers and Systems (CAHPS?) Benchmarking Database have shown that racial/ethnic minorities have worse reports of care than Whites in commercial, Medicare, and Medicaid managed care. ⁽⁷⁻¹²⁾ The 2010 National Healthcare Disparities Report (NHDR) tracked CAHPS patient-provider communication from 2002-2007.⁽¹³⁾ It found:

- 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.

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 have problems understanding their doctors are more likely than those who have 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%).(14)

Results from the CAHPS Cultural Competence Item Set have been similar. For example,

- Blacks reported the most discrimination due to race/ethnicity (12%), while Whites reported the least discrimination (6%). Logistic regression results show that respondents who were Black had higher odds of reporting discrimination based on race/ethnicity than White respondents.(15)

- One study found that African-Americans and Latinos were less likely than Whites to report poor cultural competency as measured by the CAHPS Cultural Competence Item Set. The authors posit this is because all of the patients were recruited from the safety-net setting. Many more of the White patients seeking care in these settings are homeless, use illicit substances, or have ongoing psychiatric illness than Latino and African-American patients. It may be that White patients experience less culturally competent care not because of their race but because of these other co-morbidities, although further research will be needed to fully understand why Whites report less culturally competent care in this setting.(16)

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.

1. Commonwealth Fund. 2001 Health Care Quality Survey. Available at: <http://www.commonwealthfund.org/Surveys/2001/2001-Health-Care-Quality-Survey.aspx>. Accessed February 1, 2012.
2. LaVeist TA, Nickerson KJ, Bowie JV. Attitudes about racism, medical mistrust, and satisfaction with care among African American and white cardiac patients. *Med Care Res Rev*. 2000;57 Suppl 1:146-161.
3. Bird ST, Bogart LM, Delahanty DL. Health-related correlates of perceived discrimination in HIV care. *AIDS Patient Care STDS*. Jan 2004;18(1):19-26.
4. Hausmann LR, Kressin NR, Hanusa BH, Ibrahim SA. Perceived racial discrimination in health care and its association with patients' healthcare experiences: does the measure matter? *Ethn Dis*. Winter 2010;20(1):40-47.
5. Benkert R, Peters RM, Clark R, Keves-Foster K. Effects of perceived racism, cultural mistrust and trust in providers on satisfaction with care. *J Natl Med Assoc*. Sep 2006;98(9):1532-1540.
6. Sorkin DH, Ngo-Metzger Q, De Alba I. Racial/ethnic discrimination in health care: impact on perceived quality of care. *J Gen Intern Med*. May 2010;25(5):390-396.
7. Weech-Maldonado R, Fongwa MN, Gutierrez P, Hays RD. Language and regional differences in evaluations of Medicare managed care by Hispanics. *Health Services Research*. Apr 2008;43(2):552-568.
8. Weech-Maldonado R, Morales LS, Elliott M, Spritzer K, Marshall G, Hays RD. Race/ethnicity, language, and patients' assessments of care in Medicaid managed care. *Health Services Research*. Jun 2003;38(3):789-808.
9. Weech-Maldonado R, Gutierrez P, Hays R. Hispanic ethnicity, language, and patient experiences with medicare managed care. *Gerontologist*. Oct 2004;44:294-294.
10. Weech-Maldonado R, Elliott MN, Morales LS, Spritzer K, Marshall GN, Hays RD. Health plan effects on patient assessments of medicaid managed care among racial/ethnic minorities. *Journal of General Internal Medicine*. Feb 2004;19(2):136-145.
11. Morales LS, Elliott MN, Weech-Maldonado R, Spritzer KL, Hays RD. Differences in CAHPS (R) adult survey reports and ratings by race and ethnicity: An analysis of the national CAHPS (R) benchmarking data 1.0. *Health Services Research*. Jul 2001;36(3):595-617.
12. Fongwa MN, Cunningham W, Weech-Maldonado R, Gutierrez PR, Hays RD. Reports and Ratings of Care: Black and White Medicare Enrollees. *Journal of Health Care for the Poor and Underserved*. Nov 2008;19(4):1136-1147.
13. 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.
14. 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.
15. Weech-Maldonado R, Hall A, Bryant T, Jenkins KA, Elliott MN. Does Perceived Discrimination Affect Patient Experiences with Health Care? *Medical Care* (under review).
16. Stern RJ, Fernandez A, Jacobs EA, Neilands TB, Weech-Maldonado R, Quan J, Carle A, Seligman HK. Risk Factors for Reporting Poor Cultural Competency Among Patients with Diabetes in Safety Net Clinics. *Medical Care* (under review).

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.

Among the strategies that have been advocated for reducing racial/ethnic differences in patient experiences is the provision of “culturally competent” care.(1,2) The National Quality Forum (NQF) (p. 2) recently defined cultural competency as the “ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based, and equitable.”(3) The following is a direct quote from NQF’s “A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report.”

“For too long healthcare received by minority populations has been of poorer quality; even when factors such as access, health insurance, and income are taken into account. Unless these inequities are addressed and care becomes more patient centered, these disparities in health and healthcare will persist. One major contributor to healthcare disparities is a lack of culturally competent care.

Even as healthcare systems improve, without the provision of culturally appropriate services, medical errors, misunderstandings, and a lack of patient adherence may still increase because of differences in language or culture. Providing culturally appropriate services not only has the potential to reduce disparities and improve outcomes, but it also can create greater patient satisfaction and help to increase the efficiency of clinical and support staff.”

Many organizations have set about to improve the cultural competence of health care providers. For example, the Department of Health and Human Services (HHS) Office of Minority Health has developed a set of Cultural Competency Curriculum Modules(4) that aim to equip providers with cultural and linguistic competencies to help promote patient-centered care based on the National Standards on Culturally and Linguistically Appropriate Services. Another example, which is being administered by the Health Resources and Services Administration, is the Unified Health Communication, a Web-based course for providers that integrates concepts related to health literacy with cultural competency and LEP.(5) It is therefore important to have measures of how well these efforts to improve cultural competence are succeeding.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) project has resulted in a set of standardized survey instruments that can be used to collect reliable information from patients about the care they have received. These evaluations provide important information about how well health plans and providers meet the needs of the people they serve.(6) CAHPS data have been used to assess racial/ethnic and language differences in patient experiences with care.(7-10) However, there are concerns that the CAHPS instrument does not fully capture domains of care of particular relevance to people of color.(1) The CAHPS Cultural Competence Item Set addresses this gap by assessing aspects of cultural competency not adequately addressed in the existing CAHPS surveys.

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

1. Ngo-Metzger Q, Telfair, J., Sorkin, D., Weidmer, B., Weech-Maldonado, R., Hurtado, M., and Hays, R.D.,. Cultural Competency and Quality of Care: Obtaining the Patient’s Perspective. NY: Commonwealth Fund; 2006.
2. Weech-Maldonado R, Dreachslin JL, Dansky KH, et al. Racial/ethnic diversity management and cultural competency: The case of Pennsylvania hospitals. *Journal of Healthcare Management* 2002;47:111-126.
3. National Quality Forum. A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency. Washington DC: National Quality Forum; 2008.
4. U.S. Department of Health and Human Services, Office of Minority Health. Think Cultural Health: bridging the health care gap through cultural competency continuing education programs. Available at: www.thinkculturalhealth.hhs.gov. Accessed January 31, 2012.
5. U.S. Department of Health and Human Services Health Resources and Services Administration. Unified health communication (UHC): addressing health literacy, cultural competency, and limited English proficiency. Available at:

<http://www.hrsa.gov/publichealth/healthliteracy/index.html>. Accessed January 31, 2012.

6. Crofton C, Lubalin JS, Darby C. Foreword. *Medical Care* 1999;37:MS1-MS9.
7. Weech-Maldonado R, Morales LS, Spritzer K, et al. Racial and ethnic differences in parents' assessments of pediatric care in Medicaid managed care. *Health Services Research* 2001;36:575-594.
8. Weech-Maldonado R, Morales LS, Elliott M, et al. Race/ethnicity, language, and patients' assessments of care in Medicaid managed care. *Health Services Research* 2003;38:789-808.
9. Weech-Maldonado R, Elliott MN, Morales LS, et al. Health plan effects on patient assessments of Medicaid managed care among racial/ethnic minorities. *Journal of General Internal Medicine* 2004;19:136-145.
10. Weech-Maldonado R, Fongwa MN, Gutierrez P, et al. Language and regional differences in evaluations of Medicare managed care by Hispanics. *Health Services Research* 2008;43:552-568.

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

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/Cultural-Competence.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' Cultural Competence measures be calculated using the top box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses.

Two composites can be calculated from the item set: 1) Providers are caring and inspire trust (5 items), and 2) Providers are polite and considerate (3 items).

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 indicated in parentheses.

Note that for CU1, CU2, CU3, CU4, CU5, CU14, CU15, CU24, and CU33 the most positive response is "Never." Specific instructions for how reverse coding can be done in SAS can be found in "Instructions for Analyzing CAHPS Data" (available at: https://www.cahps.ahrq.gov/Surveys-Guidance/Dental/~media/Files/SurveyDocuments/Dental/Prep_Analyze/2015_instructions_for_analyzing_data.pdf) in the section called "Data Set Specification."

CU1 In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English? (Never)

CU2 In the last 12 months, how often did this provider use medical words you did not understand? (Never)

CU3 In the last 12 months, how often did this provider talk too fast when talking with you? (Never)

CU4 In the last 12 months, how often did this provider ignore what you told him or her? (Never)

CU5 In the last 12 months, how often did this provider interrupt you when you were talking? (Never)

CU6 In the last 12 months, how often did this provider show interest in your questions and concerns? (Always)

CU7 In the last 12 months, how often did this provider answer all your questions to your satisfaction? (Always)

CU8 In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Never)

CU11 In the last 12 months, has this provider ever asked you if you have used an acupuncturist or an herbalist to help with an illness or to stay healthy? (Yes)

CU13 In the last 12 months, has this provider ever asked you if you used natural herbs? (Yes)

CU14 In the last 12 months, how often have you been treated unfairly at this provider's office because of your race or ethnicity? (Never)

CU15 In the last 12 months, how often have you been treated unfairly at this provider's office because of the type of health insurance you have or because you don't have health insurance? (Never)

- CU16 In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else? (Yes, definitely)
- CU17 In the last 12 months, did you feel you could trust this provider with your medical care? (Yes, definitely)
- CU18 In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news? (Yes, definitely)
- CU19 In the last 12 months, did you feel this provider cared as much as you do about your health? (Yes, definitely)
- CU20 In the last 12 months, did you feel this provider really cared about you as a person? (Yes, definitely)
- CU21 Using any number from 0 to 10, where 0 means that you do not trust this provider at all and 10 means that you trust this provider completely, what number would you use to rate how much you trust this provider? (9-10)
- CU24 In the last 12 months, how often were you treated unfairly because you did not speak English very well? (Never)
- CU26 In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge? (Yes)
- CU27 In the last 12 months, how often did you use an interpreter provided by this office to help you talk with this provider? (Always)
- CU29 In the last 12 months, how often did this interpreter treat you with courtesy and respect? (Always)
- CU30 Using any number from 0 to 10, where 0 is the worst interpreter possible and 10 is the best interpreter possible, what number would you use to rate this interpreter? (9-10)
- CU32 Did any of your appointments start late because you had to wait for an interpreter? (No)
- CU33 In the last 12 months, how often did you use friends or family members as interpreters? (Never)
- CU34 In the last 12 months, did you use friends or family members as interpreters because that was what you preferred? (Yes)

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 and ethnicity can be done using the following Core items:

31: Are you of Hispanic or Latino origin or descent?

32. What is your race? Mark one or more.

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 Providers Are Caring and Inspire Trust Composite consists of 5 items in the composite:

CU16. In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else? (Response: Never/Sometimes/Usually/Always)

CU17. In the last 12 months, did you feel you could trust this provider with your medical care? (Response: N/S/U/A)

CU18. In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news? (Response: N/S/U/A)

CU19. In the last 12 months, did you feel this provider cared as much as you do about your health? (Response: N/S/U/A)

CU20. In the last 12 months, did you feel this provider really cared about you as a person? (Response: N/S/U/A)

The Providers Are Polite and Considerate Composite consists of 3 items:

CU3. In the last 12 months, how often did this provider talk too fast when talking with you? (Response: N/S/U/A)

CU5. In the last 12 months, how often did this provider interrupt you when you were talking? (Response: N/S/U/A)

CU8. In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Response: N/S/U/A)

To calculate the Providers Are Caring and Inspire Trust Composite:

STEP1: Calculate the proportion of respondents in each response category for each item in the composite (i.e., the number of respondents who gave the response divided by the total number of respondents who answered that item). Start by calculating for CU16:

- The proportion of respondents who answered "never"
- The proportion of respondents who answered "sometimes"
- The proportion of respondents who answered "usually"
- The proportion of respondent who answered "always"

Follow this step for CU17, CU18, CU19, and CU20.

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

(Proportion of respondents who answered "always" to CU16 + Proportion of respondents who answered "always" to CU17 + Proportion of respondents who answered "always" to CU18 + Proportion of respondents who answered "always" to CU19 + Proportion of respondents who answered "always" to CU20)/5

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

Additional detail on the algorithm to calculate these composites is available from the CAHPS® Clinician & Group Surveys Instructions for Patient Experience 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

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 Surgical Care Survey 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.

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

Required for Composites and PRO-PMs.

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

If other, please describe in S.24.

Instrument-Based Data

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

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

CAHPS Cultural Competence Item Set. Below is listed the complete item set, including items that are not measures and items from the core Clinician and Group CAHPS that can be use for stratification and analytic purposes.

Core 1. Our records show that you got care from the provider named below in the last 12 months.

Name of provider label goes here

Is that right?

☐ Yes

☐ No If No, go to #core question 26

CU1. In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

CU2. In the last 12 months, how often did this provider use medical words you did not understand?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

CU3. In the last 12 months, how often did this provider talk too fast when talking with you?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

CU4. In the last 12 months, how often did this provider ignore what you told him or her?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

CU5. In the last 12 months, how often did this provider interrupt you when you were talking?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

CU6. In the last 12 months, how often did this provider show interest in your questions and concerns?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

CU7. In the last 12 months, how often did this provider answer all your questions to your satisfaction?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

CU8. In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

CU9. People sometimes see someone else besides their providers or specialists to help with an illness or to stay healthy. In the last 12 months, have you ever used an acupuncturist?

- ☐ Yes
- ☐ No

CU10. In the last 12 months, have you ever used an herbalist?

- ☐ Yes
- ☐ No

CU11. In the last 12 months, has this provider ever asked you if you have used an acupuncturist or an herbalist to help with an illness or to stay healthy?

- ☐ Yes
- ☐ No

CU12. Some people use natural herbs for health reasons or to stay healthy. Natural herbs include things such as ginseng, green tea, and other herbs. People can take them as a pill, a tea, oil, or a powder. In the last 12 months, have you ever used natural herbs for your own health?

- ☐ Yes
- ☐ No

CU13. In the last 12 months, has this provider ever asked you if you used natural herbs?

- ☐ Yes
- ☐ No

- CU14. In the last 12 months, how often have you been treated unfairly at this provider's office because of your race or ethnicity?
- ☐ Never
 - ☐ Sometimes
 - ☐ Usually
 - ☐ Always
- CU15. In the last 12 months, how often have you been treated unfairly at this provider's office because of the type of health insurance you have or because you do not have health insurance?
- ☐ Never
 - ☐ Sometimes
 - ☐ Usually
 - ☐ Always
- CU16. In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else?
- ☐ Yes, definitely
 - ☐ Yes, somewhat
 - ☐ No
- CU17. In the last 12 months, did you feel you could trust this provider with your medical care?
- ☐ Yes, definitely
 - ☐ Yes, somewhat
 - ☐ No
- CU18. In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news?
- ☐ Yes, definitely
 - ☐ Yes, somewhat
 - ☐ No
- CU19. In the last 12 months, did you feel this provider cared as much as you do about your health?
- ☐ Yes, definitely
 - ☐ Yes, somewhat
 - ☐ No
- CU20. In the last 12 months, did you feel this provider really cared about you as a person?
- ☐ Yes, definitely
 - ☐ Yes, somewhat
 - ☐ No
- CU21. Using any number from 0 to 10, where 0 means that you do not trust this provider at all and 10 means that you trust this provider completely, what number would you use to rate how much you trust this provider?
- ☐ 0 Do not trust this provider at all
 - ☐ 1
 - ☐ 2
 - ☐ 3
 - ☐ 4
 - ☐ 5
 - ☐ 6
 - ☐ 7
 - ☐ 8
 - ☐ 9
 - ☐ 10 Trust this provider completely
- CU22. What is your preferred language?

- ☐ English If English, go to #core question 24
- ☐ American Sign Language
- ☐ [INSERT LANGUAGE 1]
- ☐ [INSERT LANGUAGE 2]
- ☐ [INSERT LANGUAGE 3]
- ☐ [INSERT LANGUAGE 4]
- ☐ [INSERT LANGUAGE 5]
- ☐ [INSERT LANGUAGE 6]
- ☐ [INSERT LANGUAGE 7]
- ☐ [INSERT LANGUAGE 8]
- ☐ [INSERT LANGUAGE 9]
- ☐ Other

CU23. How well do you speak English?

- ☐ Very well If Very well, go to #CU25
- ☐ Well
- ☐ Not well
- ☐ Not at all

CU24. In the last 12 months, how often were you treated unfairly because you did not speak English very well?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

CU25. An interpreter is someone who helps you talk with others who do not speak your language. Interpreters can include staff from the doctor's office or telephone interpreters. In the last 12 months, was there any time when you needed an interpreter at this doctor's office?

- ☐ Yes
- ☐ No If No, go to ## CU33

CU26. In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge?

- ☐ Yes
- ☐ No

CU27. In the last 12 months, how often did you use an interpreter provided by this office to help you talk with this provider?

- ☐ Never If Never, go to #CU33
- ☐ Sometimes
- ☐ Usually
- ☐ Always

CU28. In the last 12 months, when you used an interpreter provided by this office who was the interpreter you used most often?

- ☐ A nurse, clerk, or receptionist from this office
- ☐ An interpreter provided in-person by this office
- ☐ A telephone interpreter provided by this office
- ☐ Someone else provided by this office

CU29. In the last 12 months, how often did this interpreter treat you with courtesy and respect?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

CU30. Using any number from 0 to 10, where 0 is the worst interpreter possible and 10 is the best interpreter possible, what

number would you use to rate this interpreter?

- ☐ 0 Worst interpreter possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best interpreter possible

CU31. In the last 12 months, did any of your appointments with this provider start late?

- ☐ Yes
- ☐ No If No, go to #CU33

CU32. Did any of your appointments start late because you had to wait for an interpreter?

- ☐ Yes
- ☐ No

CU33. In the last 12 months, how often did you use a friend or family member as an interpreter when you talked with this doctor?

- ☐ Never If Never, go to #core question 24
- ☐ Sometimes
- ☐ Usually
- ☐ Always

CU34. In the last 12 months, did you use friends or family members as interpreters because that was what you preferred?

- ☐ Yes
- ☐ No

Core 26. In general, how would you rate your overall health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

Core 27. In general, how would you rate your overall mental or emotional health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Core 28. What is your age?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

Core 29. Are you male or female?

- ☐ Male
☐ Female

Core 30. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
☐ Some high school, but did not graduate
☐ High school graduate or GED
☐ Some college or 2-year degree
☐ 4-year college graduate
☐ More than 4-year college degree

Core 31. Are you of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
☐ No, not Hispanic or Latino

Core 32. What is your race? Mark one or more.

- ☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native
☐ Other

Core 33. Did someone help you complete this survey?

- ☐ Yes
☐ No Thank you.
Please return the completed survey in the postage-paid envelope.

Core 34. How did that person help you? Mark one or more.

- ☐ Read the questions to me
☐ Wrote down the answers I gave
☐ Answered the questions for me
☐ Translated the questions into my language
☐ Helped in some other way
Please print: _____

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

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

Clinician : Group/Practice, Clinician : Individual

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

Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form
[1904_MeasureTesting_MSFS.0_Data.doc](#)

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

Other

If other: [Fielding CAHPS Cultural Competence Item Set](#)

3b. Electronic Sources

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

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

[Some data elements are in defined fields in electronic sources](#)

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

[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.

[As has been observed in other studies, achieving a high response rate among Medicaid beneficiaries is extremely difficult. Despite a multi-prong effort \(2 mailings, an 800 number to request a copy of the survey materials in Spanish, telephone follow ups in English and Spanish and an incentive of \\$10 was offered to non-respondents after the second call attempt\) the response rate on reached 26%.](#)

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

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
<p>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.</p> <p>Attachment:</p>
Contact Information
<p>Co.1 Measure Steward (Intellectual Property Owner): Agency for Healthcare Research and Quality</p> <p>Co.2 Point of Contact: Pamela, Owens, Pam.Owens@ahrq.hhs.gov, 301-427-1412-</p> <p>Co.3 Measure Developer if different from Measure Steward: Agency for Healthcare Research and Quality</p> <p>Co.4 Point of Contact: Cindy, Brach, cindy.brach@ahrq.hhs.gov, 301-427-1444-</p>
Additional Information
<p>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. The members of the survey development team were:</p> <p>Adam Carle - University of Cincinnati Charles Darby - AHRQ Robert Weech-Maldonado – University of Alabama Beverly Weidmer - RAND Margarita Hurtado - Hurtado Quyen Ngo-Metzger - Health Resources and Services Administration Ron D. Hays - RAND</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance</p> <p>Ad.2 Year the measure was first released: 2011</p> <p>Ad.3 Month and Year of most recent revision: 01, 2012</p> <p>Ad.4 What is your frequency for review/update of this measure?</p> <p>Ad.5 When is the next scheduled review/update for this measure?</p>
<p>Ad.6 Copyright statement:</p> <p>Ad.7 Disclaimers:</p>
Ad.8 Additional Information/Comments: