
April 24, 2017

Contract Number: 2000007495

Submitted to:
National Academy of Sciences
Project Director: Lyla Hernandez

Submitted by:
National Committee for Quality Assurance
1100 13th St NW, Suite 1000
Washington, DC 20005
Telephone: (202) 955-3500
Facsimile: (202) 955-3599

Project Director: Sarah Hudson Scholle
NCQA Staff: Jessica Briefer French
           Judy Ng
           Madhyatu Taylor

DISCLAIMER: The authors are responsible for the content of this article, which does not necessarily represent the views of the National Academies of Sciences, Engineering, and Medicine.
Executive Summary

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

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

Building on evidence about the common elements of effective interventions to improve patient understanding and engagement in health care, and essential components of a care system for addressing health literacy, language access and cultural competence, we propose an integrated patient-centered framework for measurement.

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

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

- Use structure measures to build capacity and demonstrate capability to serve diverse population needs
- Develop streamlined tools and new techniques to gather patient experiences
- Stratify existing quality measures to target improvement and equity
- Develop packages of measures for vulnerable subpopulations.

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

Health literacy, language access and cultural competence are commonly suggested concepts that address the provision of quality care to diverse and at-risk populations, including those facing persistent health care disparities based on individual characteristics, such as race, ethnicity, or culture; as well as communication, literacy and language needs.\(^1\)\(^2\) Although health literacy, language access and cultural competence are linked concepts and share commonalities – including overlapping populations, similar implications for care providers or organizations, and the primary goal of improving quality of care – each concept has grown out of distinct histories that emphasize different aspects of care, sub-goals, and patient subgroups that do not always overlap (e.g., health literacy efforts tend towards improving quality for a broad array of patients; language access and cultural competence efforts tend towards improving quality by focusing on racial/ethnic minorities or other at-risk populations).\(^1\)\(^3\)

These separate histories have resulted in fragmentation – with different constituencies advocating their own quality improvement approaches, and multiple quality measures to monitor at-risk populations – that makes implementation challenging, especially in an era of complaints about proliferating quality measures and demands for measure alignment across payers and settings. Both public and private entities have acknowledged the existence of multiple measures, and there have been important efforts to align measures across different settings. For example, efforts to enhance measure alignment and reduce complexity have been underway via the National Academies of Science, Engineering and Medicine’s (NASEM’s) Vital Signs, and the Core Quality Measure Collaborative involving the Centers for Medicare & Medicaid Services (CMS), America’s Health Insurance Plans (AHIP) and multiple other public and private entities.\(^4\)\(^5\)

The rapid expansion of value-based payment models has presented further opportunities and challenges for at-risk populations. Value-based payment programs aim to reward providers for the quality – not just the quantity – of care provided.\(^6\) For example, the implementation of CMS’s new Merit-Based Incentive Payment System ties payment directly to clinician performance in four areas: quality, resource use, clinical practice improvement activities, and advancing care information (meaningful use of electronic


health records). In the wake of this shift to value-based payment, there is growing recognition that social risk factors – e.g., race/ethnicity, income, education, environmental factors and available resources – should play a role in quality measurement. \(^7\) \(^8\) \(^9\) Because it may take more resources to care for patients with these social risk factors – and because it may be more difficult to achieve higher performance on quality of care measures – there are concerns that value-based payments may have unintended consequences for providers who care for such at-risk populations. \(^8\) \(^9\) \(^10\) Strategies for addressing these issues include measuring health equity, setting high standards for all populations and considering incentives for organizations that achieve or improve performance for at-risk populations. \(^10\) These may include strategies to address the unique needs of these populations as it relates to health literacy, language access and cultural competence, all of which may disproportionately affect populations facing multiple social risk factors.

An integrated framework for addressing health literacy, language access and cultural competence will support greater attention to these concepts in value-based payment arrangements. Because quality metrics play a key role in understanding performance, in identifying care gaps, and in accountability via value-based payment mechanisms, measurement approaches will be foundational to improving care. To that end, the purpose of this paper is to establish a framework to integrate measurement of health literacy, language access and cultural competence, with the primary goal of using this integrated measurement approach to improve care quality and reduce disparities. While we have been referring to three general terms – health literacy, language access, cultural competence – the remainder of this paper further defines other relevant concepts (e.g., communication and language assistance as an expansion of language access), explores opportunities for alignment between multiple linked concepts, provides examples of known effective interventions addressing these concepts, details opportunities for quality measurement and offers recommendations for using an integrated, patient-centered framework, to guide broader implementation and evaluation of these critical aspects of care.

2.0 DEFINITIONS OF CONCEPTS

In this section, we provide further detail regarding the definitions and background for the three general concepts of health literacy, language access and cultural competence. For each concept, we provide a summary that aims to address the following: 1) how is the concept defined? 2) when was the concept first notably publicized and/or when did it gain wider attention? 3) what is the scope of the problem? and 4) what are implications for health care? We also describe recent efforts to use more expansive concepts as presented in the enhanced National Standards for Culturally and Linguistically Appropriate

---


Services as well as the simultaneous efforts to promote the broadly defined concept of patient-centered care. Definitions of these concepts are provided in Exhibit 1.

2.1 General Concepts: Health Literacy, Language Access and Cultural Competence

Health Literacy

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

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

Health literacy broadly affects one’s ability to navigate the health system and manage one’s condition(s), with important health and health care implications. Low health literacy has been linked to poor outcomes, such as higher rates of hospitalization and use of emergency services, and less frequent use of preventive services – all of which are associated with higher healthcare costs. There are existing tools that assess health literacy levels, which can be used for quality improvement, training and program planning purposes. However, there are important challenges, including evolving definitions and questions about the usefulness of such assessments, given the near universality of the problem and recommendations for a “universal precautions” approach.

Language Access

The U.S. Department of Health and Human Services (DHHS) 2013 Language Access Plan defines language access as being achieved “when individuals with [limited English proficiency] LEP can communicate effectively with HHS employees and contractors and participate in HHS programs and activities.”1,18 To facilitate language access, care providers, organizations and other entities may provide “language assistance,” defined as “all oral and written language services needed to assist individuals with LEP to communicate effectively with HHS staff and contractors and gain meaningful access and equal opportunity to participate in the services, activities programs or other benefits administered by the HHS.”17 Viewed alternatively, and as framed by NASEM, language access “focuses on equity,” while language assistance “focuses on the methods of service delivery, whether it be in-person sign language or spoken language interpreters, video remote interpreting, or remote simultaneous medical interpreting.”1

The issue of language access is not new, having gained national attention in the 1960s, when Title VI of the Civil Rights Act of 1964 required recipients of Federal financial assistance to take “reasonable steps” to consider persons with LEP within their programs and activities.19 Language access has also expanded to include communication issues beyond LEP – including the communication needs of people with visual, hearing or speech disabilities – and as such, other important U.S. regulations also address language access, e.g., the Americans with Disabilities Act (ADA) and the U.S. Department of Justice’s regulations to implement ADA requirements.20 We further discuss communication and language assistance under the expanded concepts section, below.

It is estimated that 24.5 million people (8.6 percent) in the U.S. have LEP.21 The health implications are broad: LEP is associated with the higher risk of being uninsured, as well as medical errors and various patient safety problems, to name a few.2,19 The problems associated with LEP makes language access critical for achieving access to care and high quality care. The diversity of people with LEP also means that language access efforts must account for the diversity of languages that the population may use.

Cultural Competence

The U.S. Department of Health and Human Services issued a set of National Culturally and Linguistically Appropriate Services (CLAS) Standards defining cultural competence as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.”22 Cultural competence may be viewed as a strategy health

---

care providers, organizations and other entities use to improve quality of care and reduce health care disparities, primarily by providing services that are respectful of and responsive to diverse populations, including populations that vary by race, ethnicity, culture, or language proficiency. Cultural competence may also be viewed as the ability of – not just a strategy used by – providers and entities to provide such services.¹

The term “cultural competence” began emerging more consistently in relation to health care in the 1990s.³ An important driver behind this was the increasing diversity of the U.S. population, with clinicians seeing patients with more varying perspectives regarding health, as influenced by their social or cultural background.¹,²² Another important driver was the growing evidence of persistent racial/ethnic disparities in health care and the importance of providing culturally competent, patient-centered care to address these disparities and improve care quality.¹,³,²² Two key IOM reports shone a national spotlight on these issues: 2001’s Crossing the Quality Chasm, and 2002’s Unequal Treatment.³,²²,²⁴,²⁵ Outside the health policy and research world, an acclaimed 1997 book and winner of the National Book Critics Circle Award, The Spirit Catches You and You Fall Down, by Anne Fadiman, brought the discussion of “ways in which American medicine is practiced across cultures” further into medical and other circles, and highlighted the important difference between cultural constructs related to health and illness.²⁶

As the population of racial and ethnic minorities continues growing, the cultural competence movement is expected to continue expanding. The U.S. Census Bureau estimates that by 2020, the majority of U.S. children will be part of a minority racial or ethnic group, with the U.S. population as a whole expected to follow this trend: by 2060, the minority population is projected to rise to 56 percent of the total population – up from 38 percent in 2014.²⁷ Given the known problems associated with gaps in culturally competent care, the implications for health care are pronounced. There is evidence that the lack of cultural competence presents care barriers for many populations, including barriers related to cancer screenings and care, mental health diagnosis and treatment, maternal health outcomes, and sexually transmitted disease.² The delivery of culturally competent care will be especially salient in addressing the disparities that affect diverse populations.

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

More recent efforts to expand and align the focus of health literacy, language access and cultural competence have pointed out the interrelatedness of these concepts and suggested new terminology. One important effort is the enhancement of the DHHS National CLAS Standards (revised and updated in

2013) that introduced more expansive terms relating to communication and language access, culture and understandable care. In particular, the enhanced standards expand the concept of culture to be more explicitly inclusive of populations beyond racial and ethnic minorities. The enhancement also adds “communication and language assistance” as a theme beyond language access, to better acknowledge communication needs beyond LEP. Finally, the enhancement expands the concept of understandable care to address broader aspects of care and services, and incorporates health literacy concepts. This section briefly summarizes each of these three expanded concepts.

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

**Culture**

The enhanced National CLAS Standards adapt a broader definition of culture to refer to “the integrated pattern of thoughts, communications, actions, customs, beliefs, values and institutions associated wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics.” The enhanced definition more explicitly recognizes the broad manifestations of culture, beyond just racial and ethnic minorities, and also provides “increased opportunity...to identify and use similarities” to improve health care and quality. (DHHS 2013)

**Communication and Language Assistance**

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

**Understandable Care and Services**

Under the enhanced standards, understandable care and services “rely on a clear exchange of information between those providing care and services and those receiving them. Individuals should be able to fully comprehend how to access care and services, what their treatment options are, and what they need to get and stay well. Ensuring that care and services are understandable is particularly important to those who have limited English proficiency, are deaf or hard of hearing, or may have difficulty comprehending the health care system and its terminology.” This definition more explicitly acknowledges the same concepts that are salient to health literacy, including the importance of conceptual knowledge and comprehension, and the need to ensure health information is

---

comprehensible even to those who may have hearing or other impairments. This definition also focuses on the responsibility of the healthcare organization to provide effective communication.

**Culturally and Linguistically Appropriate Services (CLAS)**

Commonly defined as health care services that are respectful of and responsive to cultural and linguistic needs, the provision of CLAS has been identified as an important approach to addressing health care disparities based on race, ethnicity, culture, language needs, health literacy and communication needs. At its core, both the original and enhanced National CLAS Standards provide an organizing framework in which health care providers and organizations may provide care and services to meet the needs of diverse populations, under the reasoning that CLAS respond to demographic and other differences, reduce disparities, and improve quality of care. The enhanced National CLAS Standards specifically focuses on areas pertaining to 1) effective, equitable, understandable and respectful care, 2) governance, leadership and workforce, 3) communication and language assistance, and 4) engagement, continuous improvement and accountability. (DHHS 2013) The standards also provide an additional framework for integrating concepts that may address health literacy, language access and cultural competence – with the enhanced standards acknowledging the broader definitions and interrelated constructs that may be entailed within the three concepts.

**Patient-Centered Care**

Simultaneous with the rise in efforts to promote health literacy, communication and language assistance and cultural competence, the concept of “patient-centered care” has gained broad support. Patient-centered care is defined in the IOM’s seminal 2001 report, *Crossing the Quality Chasm*, as a core component of quality and includes care that is “respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” The concept of patient-centeredness in care is not new, however, having first emerged in the 1960s. The primary aim of patient-centered care is broader than that of – for example – language access or cultural competence, as it emphasizes individualized care, as well as the patient-provider relationship, that may elevate quality of care for all patients – not just a cultural, linguistic or other subgroup. In the 1990s, the Picker Institute – along with the Commonwealth Fund – further defined eight dimensions (“principles”) of patient-centered care, including: respect for patients’ values, preferences and expressed needs; coordination and integration of care; information, communication and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family and friends; transition and continuity; and access to care. Many of these principles are directly related to the concepts of health literacy, language access and cultural competence. With the publication of the IOM’s 2001 report, the patient-centered care concept was notably “enshrined” and pushed into prominent, national discussion.

Patient-centered care may be applied at many levels, not just that of the patient-provider relationship, including that of a health care practice, a hospital, a health care plan or system. This philosophy of

---


patient-centered care involves an organizational focus that incorporates patient’s individual needs and preferences through all levels of care delivery and the care system. Indeed, the Patient-Centered Medical Home (PCMH) has currently evolved as a promising model for improving health care and redefining how primary health is organized and delivered.\(^{31}\)

In the next chapter, we propose an integrated, patient-centered framework for integrating the concepts of health literacy, communication and language assistance and cultural competence, and we describe the common domains that link these concepts to each other and to patient-centered care.

---

PROPOSED FRAMEWORK FOR MEASURE ALIGNMENT

To better understand opportunities for measurement integration, we propose an integrated, patient-centered framework for aligning the concepts of health literacy, communication and language assistance, cultural competence and patient-centered care (Exhibit 2). Although the original charge for this paper was to suggest an integrated framework for measurement of health literacy, cultural competence and language access, we have applied the broader terms or meanings as described in the enhanced National CLAS Standards, including communication and language assistance, and we include patient-centered care as a complementary and expansive approach to addressing similar or related concerns. For each area, we identify the components, activities or expectations based on authoritative sources and where relevant, evidence-based interventions that have been demonstrated to address health literacy, improve cultural competence, patient understanding and patient engagement. We posit that these components that are well aligned are strong candidates for integrated, patient-centered measurement.

3.1 Evidence for effective interventions to address health literacy, communication and language assistance and cultural competence

There is a growing body of evidence demonstrating effective interventions for addressing health literacy, communication and language access and cultural competence, as well as patient-centered care. The evidence shows several common themes across these concepts. Below, we summarize the evidence for successful interventions that address health literacy, communication and language assistance, cultural competence and patient-centered care, respectively. Following this brief review of the evidence, we identify common domains across these concepts.

Health literacy

Healthcare organizations can bridge literacy barriers for individual patients by determining patients’ ideal learning styles during intake assessments and providing materials in a variety of media targeted to the patient’s proficiency. Although methods exist for assessing individual patients’ health literacy, given the high proportion of the population that experiences health literacy challenges, more universal approaches are recommended. The Agency for Healthcare Research and Quality has published the second edition of its Health Literacy Universal Precautions Toolkit. This toolkit offers a variety of evidence-based tools to help health care organizations communicate clearly. Tools include the Teach-Back Method, various approaches to encouraging patients to ask questions, including Ask Me 3, and a variety of tools to help organizations communicate in plain, non-technical language. In its Preferred Practices for Measuring and Reporting Cultural Competency, the NQF recommends using the Teach-Back Method to improve communication between providers and patients. Healthcare organizations can provide information in plain language with clear communication in the patient’s target language. Research shows that using interactive methods, such as Ask Me 3 and Teach-Back improve patients’

understanding and adherence to treatment recommendations\textsuperscript{34, 32} and that use of community health workers improves patient understanding of their disease and results in improved self-management and better outcomes.\textsuperscript{35}

**Communication and Language Assistance**

A key component to achieving health literacy and reducing health disparities is to ensure patients can communicate with medical personnel and obtain information about their conditions in their preferred language. Research shows that providing information in writing is associated with improved care, and that, like the health literacy intervention, visual aids were associated with better patient adherence among people with LEP.\textsuperscript{36} Studies show improved adherence among non-English speaking patients when information was provided in the patient’s preferred language. The use of trained interpreters was found to result in improved diagnoses.\textsuperscript{37} Interventions involving community health workers have also been demonstrated to improve outcomes among diabetic patients with language barriers.\textsuperscript{38}

English-speaking patients with functional disabilities such as blindness or deafness may face additional barriers in communication. Individuals with disabilities may require auxiliary aids such as assistive listening devices, video interpretive services, or braille transcription services to enable patients to fully participate in their health care.\textsuperscript{39}

**Cultural Competence**

Efforts to improve the overall cultural competence of a health care organization and its staff members require substantial engagement between the organization and the community. Community needs assessments and work with community health workers can help organizations understand the demographic and cultural profile of their communities and better deliver culturally-tailored and patient-centered care.

\textsuperscript{34} Cincinnati Children’s Hospital Medical Center. (2011). *Best evidence statement (BEST). Communication of health care information to patients and caregivers using multiple means.* Cincinnati, OH: Cincinnati Children’s Hospital Medical Center.


Chin et al described promising interventions to improve cultural competence and reduce disparities. The authors recommend culturally tailored, multi-disciplinary team-based interventions that address patients at multiple points in their interaction with the health care system. They further recommend interactive patient education approaches and family and community engagement in patient navigation efforts. The National Quality Forum recently summarized the common practices that were found to be effective in reducing disparities. These include: organizational commitment to disparities reduction and promotion of health equity; collaboration across sectors (public health and health care) to reduce disparities at all key points; collection and analysis of data to identify disparities; implementation of quality improvement activities focused on disparity reduction; engagement of the community and with patients in developing interventions; and implementation of culturally tailored, person and family-centered, multi-disciplinary, coordinated care. In particular, the authors suggest the value of community health workers in helping organizations provide culturally and linguistically tailored health education and support.

Community health workers serve as key members of the health care team, and as members of the community, can help make care more culturally sensitive. Research shows that across a variety of specific community health worker interventions and applications, health care outcomes were improved. In addition to their roles in providing patient information and supporting patient self-management for chronic conditions, community health workers can offer valuable insight to health care organizations about the values and concerns that may be common in a community or population subgroup. Chin and NQF identify community engagement as a success factor in developing targeted interventions that are acceptable to a community, and that account for the community context. Deeper understanding and appreciation for cultural practices within the community will allow the organization to be increasingly responsive and innovative when establishing policies. For example, temporarily modifying the timing of hospital events to respect religious and cultural holidays or designing patient support groups that provide tailored education that reflects different cultural norms may help all persons receive culturally appropriate health care.

Patient-centered care

While the Institute of Medicine identified patient-centered care as one of six quality aims, there is evidence that patient-centered also impacts other aspects of quality, including patient experience, effectiveness and safety. Various aspects of patient-centered care, including the patient-physician relationship, patient engagement in decision-making and support for patient self-management are each associated with improved quality. Street and Epstein suggest a variety of pathways through which physician-patient communication might affect health outcomes, with some direct (e.g., reduction of


anxiety), and others indirect (e.g., trust leading to improved adherence to medication regimen). In 2007, the major primary care associations issued the *Joint Principles of the Patient-Centered Medical Home*, and subsequently several national accrediting organizations launched accreditation programs for patient-centered medical homes. The Patient-Centered Medical Home’s Impact on Cost and Quality shows consistent reductions in utilization and cost, and specifically in unnecessary utilization, among patient-centered medical homes. While the Patient-Centered Primary Care Collaborative report focuses on cost and outcome measures, it also reports quality results where these were included in the reviewed studies, and six of seven peer-reviewed studies showed improved clinical quality on one or more measures, while one study showed mixed results.

**Summary of Evidence**

Key evidence shows some common elements of effective interventions to improve patient understanding and engagement in health care, and to improve the quality of care delivered and outcomes attained. Organizations can implement evidence-based practices to communicate clearly and in plain language, whether in-person, over the telephone or in written materials and other media, to increase patient understanding and engagement in their care. Engagement of the community, including community health workers, can support this effort in a variety of ways.

**3.2 Integrated, Patient-centered Framework Based on Common Domains**

To develop an integrated framework for measurement, we considered the evidence as well as standards or other authoritative guidelines for providing care designed to address the concepts of health literacy, communication and language access, and cultural competence, and we added the concept of patient-centered. This framework illustrates how these concepts share common domains. For many of these concepts, we refer to the National CLAS Standards. The provision of CLAS has been identified as an important approach to addressing health care disparities based on race, ethnicity, culture, language needs, health literacy and communication needs. Both the original and enhanced National CLAS Standards provide an organizing framework in which health care providers and organizations may provide care and services to meet the needs of diverse populations. Below, we present standards, activities, expectations or guidelines for each concept. These standards, promulgated by authoritative sources, and the evidence-based interventions identified previously, are well-aligned across a common set of domains. Exhibit 2 displays this alignment.

---

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

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

It may be possible to group the activities or expectations in alternative ways. However, for discussion, we describe the following domains and sub-domains:

**Organization culture/values**

The enhanced National CLAS Standards added a standard to the original set and expanded the scope of two other standards, to emphasize the important role of governance and leadership in promoting “Effective, equitable, understandable, and respectful quality care and services” (CLAS Standard #2).\(^{28}\) This construct integrates the role of organizational culture in making health care services culturally sensitive and understandable to people with LEP and people with low health literacy. The Patient-Centered Medical Home similarly identifies physician leadership of the care team as central feature of the model,\(^{44}\) whose purpose is to “foster an environment of trust and respect.”\(^{47}\) In both cases, the function of leadership is highlighted in creating a culture of respect and inclusion. Additional expectations for organizational culture and leadership include making the health care system more proactive in removing health literacy barriers and implementing incentives to promote good communication practices\(^{48}\) and to implement patient-centered care principles.\(^{47}\)

**Accountability/Quality Improvement (QI)**

National CLAS Standards,\(^{28}\) National Academy’s *Prescription to End Confusion*,\(^{13}\) the CDC’s training materials on health literacy\(^{49}\) and the Joint Principles of the Patient-Centered Medical Home\(^{44}\) all highlight the importance quality measurement, quality improvement and accountability in implementing and continually improving the effectiveness of health literacy, cultural competence, communication and language assistance and patient-centered care. CLAS Standard #10 is “Conduct Organizational Assessments” to assess progress in implementing the CLAS standards. Ongoing assessment of efforts to improve health equity and reduce disparities is key to providing continuous process improvement and focusing resources on proven outcomes. Some of the activities suggested

---


include developing plans, policies, goals and management accountability for CLAS; collection of data (patient and community demographics, quality performance); stratification of quality measures by demographic group; organizational self-assessment of capacity to provide CLAS and progress on CLAS activities. In addition to assessment, accountability/QI includes continuous improvement activity; public reporting and seeking third-party external recognition. When organizations take time to gather robust baseline information about their populations, capabilities, and processes, ongoing data regarding performance and outcomes may be collected for future analysis and quality improvement.

**Workforce**

Preparedness of the workforce through recruitment and training has been highlighted as an important domain across all these concepts. Subdomains include:

- Diverse workforce
- Training/ workforce skills.

**Diverse workforce**

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

**Training and workforce skills**

Hiring a diverse workforce is valuable, but not sufficient, for delivering culturally and linguistically appropriate services. Ongoing training and skill development is recognized across concepts as an important strategy to ensure that staff understand the expectations for performance, and have the skills to deliver culturally and linguistically sensitive care and services (CLAS Standard #4).

Epstein and Street, in a 2011 editorial in the Annals of Family Medicine, argue that training is required to shift the physician’s traditionally authoritative role to a more collaborative and empathic role that invites patient engagement. The skills needed for this role change have much in common with the skills needed to engage a diverse patient population in their health care.

**Assessment**

Needs assessment is at the core of providing individualized care and services. Numerous authorities identify assessment as a critical component of providing services that are understandable and tailored to the needs, culture and language of the patient. Assessments can inform service and resource

---


planning at the organizational level, as well as for tailoring individual care plans. The National CLAS Standards also recommend conducting organizational assessments; however, because this activity is linked to quality improvement, we have addressed that requirement in the Accountability/Quality Improvement domain. Subdomains of assessment include:

- Individual
- Community.

**Individual assessment**

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

**Community assessment**

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

**Community Engagement**

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

**Communication**

The Institute for Healthcare Communication presents evidence of the impact of communication in the healthcare setting. They describe studies that tie communication effectiveness to diagnostic accuracy, patient adherence to treatment, patient safety and patient and team satisfaction. Patient-centered care principles and shared decision-making depend on effective and supportive communication.

---

National CLAS Standards identify communication as key to avoiding malpractice, and the provision of CLAS as key to effective communication and reduction of disparities. Subdomains include:

- Materials
- Oral communication.

Materials

The Institute of Medicine recommends presenting health information in various forms and media, and in clear, every-day language. The U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion recommends using plain language, making written information look easy to read, supplementing written information with pictures, and ensuring materials reflect the cultural context, language and language skills of the intended users. National CLAS Standards #6 and #8 recommend providing written notice of the availability of language services, and providing easy-to-understand print and multimedia materials and signage in peoples’ preferred language, or the languages commonly used in the community. The Centers for Disease Control suggests using culturally and linguistically appropriate messages, and The Joint Commission recommends providing patient education materials that “meet patient needs.”

Oral Communication

The Institute of Medicine and the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion recommend using every-day language and avoiding jargon, and the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion and Epstein and Street recommend using interactive methods to directly engage patients. National CLAS Standard #5 suggests offering both language assistance services to people with LEP, and other communication supports, at no cost to the individual. The National CLAS Standards also recommend making verbal offers of language assistance, in addition to written offers. CLAS Standard #1 suggests providing understandable care and services that are culturally responsive in peoples’ preferred languages, and with any communication assistance required.

Patient engagement

The Institute of Medicine identifies several approaches to engaging patients. These include providing time for discussions between patients and providers, and helping patients to feel comfortable asking questions within a therapeutic relationship. National CLAS Standard #1, while overarching, also points to engaging patients, and Standards #5 and 7 address the provision of language services and ensuring the competency of language service providers, as a vehicle to promote and enhance patient engagement. The Joint Commission recommends that health care organizations “accommodate patient cultural, religious or spiritual beliefs and practices.” The Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities recommends using collaborative care

---

and shared decision-making. Epstein and Street recommend physicians display specific behaviors to ensure patients are engaged in their care, and the Joint Principles of the Patient-Centered Medical Home also identify patient involvement in decision-making as a core principle of the patient-centered medical home model.
4.0 OPPORTUNITIES FOR MEASUREMENT

In this chapter, we identify measurement opportunities based on the framework identified above. First we review the landscape of existing measures for structure, process and outcome. Then, we suggest streamlined and innovative approaches to take advantage of existing measures and push for future efforts to fill in gaps.

4.1 Existing measures address health literacy, communication and language assistance and cultural competence

Health care quality measures can assess structures, processes and outcomes.\textsuperscript{55} Structure refers to the infrastructure and capability of health care organizations (such as workforce and health information technology). Process measures evaluate the provision of evidence-based or recommended services. Outcomes are the endpoints and effect of care – and can include care experiences and health outcomes such as disease control or mortality and can be measured for individuals or a population.

A recent scan of existing measures found a limited number of measures addressing health literacy, communication and language assistance and cultural competence\textsuperscript{56} and even more limited use of these tools in accountability efforts. In this section, we highlight how these existing measures relate to the proposed framework.

Structure Measures

Several kinds of structure measures are available for assessing structures of care, including organizational surveys, accreditation standards and program requirements (Exhibit 3).

Surveys. Two surveys, both endorsed by the National Quality Forum, address all the domains from our integrated, patient-centered framework, but one focuses primarily on culture and language. The RAND Cultural Competency Implementation Measure\textsuperscript{57} is an organizational survey designed for web-based administration. This survey was based on a priority subset of NQF’s cultural competency preferred practices, and most of the items are framed in relation to disparities or cultural competence (e.g., “Provided staff with time and resources for training programs and practices that promote culturally competent care.”) In contrast, the Communication Climate Assessment Toolkit (C-CAT) addresses a range of communication issues including health literacy, culture, language access and other communication barriers.\textsuperscript{58} Originally developed by the American Medical Association Ethical Force program and now stewarded by the University of Colorado, this toolkit includes surveys for clinicians/staff as well as patients, and the measures for each composite are calculated from both sets of responses. We could not locate information on use of either measure in accountability programs.

\textsuperscript{55} Donabedian, A. (2005). Evaluating the Quality of Medical Care. \textit{The Milbank Quarterly,} 83(4), 691-729.


\textsuperscript{58} University of Colorado, Center for Bioethics and Humanities (n.d.). \textit{About C-CAT.} Retrieved from http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BioethicsHumanities/C-CAT/Pages/About-C-CAT.aspx
Accreditation programs. Existing accreditation standards for health care organizations also address the topics and domains of our proposed framework. A previous review of accreditation standards found that accreditation programs often have opportunities for organizations to demonstrate attention to health literacy, cultural competence and communication and language assistance. However, organizations can often achieve accreditation without meeting specific program elements related to our framework, such as collection of race/ethnicity data.

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

Health plans. NCQA’s health plan accreditation includes some attention to language needs, health literacy, and other communication needs, primarily related to health plan operations, care management and network adequacy. NCQA also has a Multicultural Healthcare Distinction program that was developed in 2010 to align with the HHS OMH CLAS standards. This distinction program adds emphasis on culture, language and disparities with requirements for data collection on race/ethnicity and language, increased expectations for language services, and requirements for quality improvement efforts related to reducing disparities or increasing cultural competence. This program has not been revised since the publication of the revised HHS OMH CLAS standards in 2013. Uptake of this specialized program is quite limited; Of more than 1,200 health plans that currently have NCQA’s Health Plan Accreditation, only 27 have NCQA’s additional Distinction in Multicultural Healthcare.

Primary care practices. NCQA’s Patient-Centered Medical Home recognition program for primary care practices includes expectations related to addressing health literacy, cultural competence and communication and language assistance and the standards address all domains of the integrated framework. Like other accreditation programs, practices are not required to meet all elements for recognition. Data from the practices recognized under the 2014 standards show that most practices met expectations for documentation of race/ethnicity and language needs, though only about 40% document health literacy assessment. Nearly all have mechanisms for referring to community resources. However, only 40% assess the usefulness of community resources. About half of the recognized practices (52%) conduct QI efforts focused on vulnerable populations.

The recently released 2017 version of the PCMH standards increases expectations relevant to our proposed framework. New expectations specially call out building a “health-literate” practice with

---

training and demonstration of communication processes like Teach-Back methods; educating staff on how to interact with people of different cultures or language needs and addressing potential disparities based on these and other patient characteristics. Still, few of these items are core or required elements; instead practices have a choice in how to achieve the required number of credits for recognition.

**Program standards.** Another example of program standards addressing our integrated, patient-centered framework comes from the Merit-Based Incentive Payment System recently introduced for Medicare clinicians. Payments to clinicians will be determined in part based on their performance in four areas: quality, costs, clinical practice improvement activities and advancing care information (meaningful use of electronic health records). Most participants will be required to attest that they completed up to 4 improvement activities for a minimum of 90 days and this will count towards 15% of the performance score. Of the 92 activities listed, four improvement activities are specifically labeled under the category “advancing health equity”:

- Engagement of new Medicaid patients and follow-up
- Leveraging a QCDR for use of standard questionnaires [for disparities reduction]
- Leveraging a QCDR to promote use of patient-reported outcome tools
- Leveraging a QCDR to standardize processes for screening

Other activities included in categories of population management and beneficiary engagement align well with the integrated, patient-centered framework (Exhibit 3). Several activities are related to topics extraneous to this framework, but that could be used as models, or adapted to address health literacy, communication and language assistance and cultural competence. For example, current improvement activities that relate to staff training (IA_PSPA_3: Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS(R) or other similar activity) or assessment of organizational safety culture (IA_PSPA_4: Administration of the AHRQ Survey of Patient Safety Culture) could be adapted to training in health literacy, communication and language assistance and cultural competence.

**Process Measures**

Only a handful of measures are available to evaluate the process of care delivery related to our integrated, patient-centered framework and concepts (Exhibit 4). Most of these measures address communication and language assistance and focus on specific healthcare settings. Only one of these measures is used in accountability programs; Medicare health plans and prescription drug plans are evaluated on the availability of communication services for members calling the health plan. A suite of measures developed for assessing the use of language services in hospitals does exist, though the NQF endorsement has lapsed. The Institute for Clinical Systems Improvement (ICSI) has published a measure targeting use of Teach-Back methods, for quality improvement purposes.

**Outcomes**

A previous review identified several survey tools available for assessing patient experience with communication, including a special focus on interpreters and cultural competence. However, we found that the only items used in accountability programs are a composite measure assessing communication

---

about medications from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Literacy item set. This composite is used in CAHPS surveys for hospitals, accountable care organizations, and other facilities; it is also in the CAHPS survey that is a measure reporting option for the Merit-Based Incentive Payment System for Medicare providers as well.

Yet validated items in the CAHPS family of measures address a broad range of topics related to cultural competence, including interpreter services, health literacy and patient-centered medical home (Exhibit 5). Each of these item sets was developed separately using different conceptual frameworks. Eight items addressing communication are common to the health literacy and cultural competence item sets; the Cultural Competence set includes additional items that address trust, experiences of discrimination, interpreters and complementary and alternative medicine; the Health Literacy Set has items related to topics such as test results, filling out forms, and self-management support (Exhibit 6 provides examples of items).

4.2 Recommendations and Next Steps
Despite the existence of relevant measures addressing the concepts of health literacy, communication and language assistance and cultural competence, the uptake of these measures in existing programs and accountability efforts has been limited. We recommend four strategies for using an integrated, patient-centered framework, and offer recommendations to guide broader implementation and evaluation of these critical aspects of care:

- Use structure measures to build capacity and demonstrate capability to serve diverse population needs
- Develop streamlined tools and new techniques to gather patient experiences
- Stratify existing quality measures to target improvement and equity
- Develop packages of measures for vulnerable subpopulations.

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

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

Existing structure measures vary in the degree to which they support the full range of the integrated framework, but there are good options for immediate implementation. Several existing measures address key structures related to the seven common domains, or important outcomes. The Communication Climate Assessment Tool offers an integrated approach for surveying clinicians and staff about these concerns and maps well to the integrated, patient-centered framework. While this tool is

---

primarily intended for internal quality improvement efforts, it could be a useful method for assessing the implementation of the framework. NCQA’s 2017 PCMH program illustrate how the integrated, patient-centered framework could be implemented in standards – in some cases the concepts of health literacy, communication and language assistance and cultural competence are called out as separate elements (e.g., training and staff preparation, data collection), and in some they are considered in tandem (as in care management and self-care). Both the RAND Cultural Competence Assessment tool and NCQA’s Multicultural Healthcare Program have a narrower framing that would need to be expanded to address broader definition of cultural and communication needs.

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

A second pathway is the implementation of patient-centered care models. The Merit-Based Incentive Payment System offers full credit for improvement activities to practices that are recognized as patient-centered medical homes. Patient-centered care is highly aligned with multiple payer priorities. Expressed as “patient and family engagement,” it is one of six priorities articulated in the National Quality Strategy. Nearly half of all states (22) require patient-centered medical home certification for participation in certain incentive programs, including federally-run initiatives such as Comprehensive Primary Care Plus, State Innovation Models, health homes and Delivery System Reform Incentive Payment Programs. The uptake of patient-centered care principles is reflected by the growth of NCQA’s Patient-Centered Medical Home Recognition program, which recognizes 12,000 practices covering 60,000 clinicians.

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

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

While structure measures lay the foundation for integrated, patient-centered care, patients and families are the authorities on whether care achieves these goals of patient-centered, culturally responsive, understandable care. Survey tools for assessing these topics exist but have not gotten traction. Current

66 NCQA (n.d.).
approaches for collecting patient experiences data use broad-based tools, target a representative
sample of the population, and rely on inexpensive methods of mailed surveys (sometimes with
telephone follow-up). These methods mean that specific needs such as communication and language
support are either not captured, or an insufficient number of individuals with such needs are sampled.
While survey response rates are declining across the general population, this may be a particularly acute
problem for language and culture, since cultural and language barriers could contribute to even lower
participation among these groups.

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

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

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

The ultimate goal of an integrated patient-centered framework is to achieve equity in health care and
outcomes across populations with diverse needs. We recommend stratifying existing clinical process
and outcome measures by various social risk factors, to assess the presence and magnitude of
disparities, and to monitor changes over time. Stratified reporting of quality results on existing measures
reported by health plans, hospitals and other provider organizations and facilities is a powerful way to
identify and target opportunities for improvement. Implementing stratified data reporting requires
substantial effort. Minnesota Community Measurement first published an equity report on health care
outcomes in 2015, seven years after they began efforts to increase documentation of race, ethnicity,
language and country of origin.\(^67\) Prior to public reporting, organizations were able to see their private
results and compare to others so that they could understand and build improvement efforts to address
these findings. Their report documents disparities in quality on five outcome measures for adults across
medical groups in Minnesota; it also highlights which clinics serve higher proportions of vulnerable
population. Similar efforts to publish data on health care equity are under way in California.\(^68,69\) Over
the past year, CMS has released three reports on disparities in Medicare Advantage health plans using

Care Performance Results in Minnesota by Race, Hispanic Ethnicity, Preferred Language and Country of Origin.

\(^{68}\) California Department of Public Health. (2016). Let’s Get Healthy California. Retrieved from
https://letsgethealthy.ca.gov

\(^{69}\) California Department of Health Care Services, Managed Care Quality and Monitoring Division. (2017).
The Managed Care Performance Dashboard. Retrieved from:
http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx
data on quality and patient experiences.\textsuperscript{70} Although several helpful and detailed toolkits exist for the collection of race, ethnicity and language data and although collection of these data have been encouraged for many years, data are substantially incomplete.\textsuperscript{71,72}

Incomplete information on social risks limits opportunities for stratified reporting. Ng et al. recently showed that most health plans – commercial, Medicaid and Medicare – lacked complete data on race, ethnicity and language needs of their members.\textsuperscript{73} For the Medicare Advantage reports, CMS used statistical methods to attribute race and ethnicity where data were incomplete using other Medicare and US Census data. As noted above, Minnesota undertook special efforts to gain complete data for their report. Systematic efforts to collect data on these factors and other factors are required to assess equity of care. Even once data on social risk factors is complete there are additional methodological challenges to address related to sampling of small population segments. Questions remain about the relevance of collecting specific information on health literacy, given estimates that the vast majority of patients experience health literacy challenges.

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

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

**Next Steps**

**More work will be needed to apply this integrated, patient-centered framework to the adaptation and development of measures that can be used for quality improvement and accountability.**

Implementing structural measures may be the most immediately available opportunity, due to the high interest in patient-centered care, and the alignment of payer incentives promoting patient-centered medical home adoption. This broader approach holds appeal for providers and healthcare organizations


because it is relevant to the entire population, and it offers the added benefit of providing an integrating framework for the concepts of health literacy, cultural competence and communication and language assistance. Ongoing research to demonstrate the benefits of patient-centered medical homes for the general population, for improving health equity and particularly for addressing the cultural and communication needs of vulnerable populations of interest, will strengthen the momentum for this approach.

Stratifying existing performance measures may be the next most immediately promising strategy, which can support the research suggested above. CMS has already begun to publish quality measures stratified by race and ethnicity. Minnesota Community Measurement, similarly, is publishing stratified performance data, and some individual healthcare organizations have developed equity dashboards for internal monitoring, demonstrating that stratification is feasible. Challenges remain, however, and improving data collection practices will be a necessary precedent step for many organizations -- an activity that can be promoted through structural measures. The work may need to proceed stepwise, beginning with incentivizing better data collection, followed by incentivizing stratification and equity-focused quality improvement before stratified quality measures are fully ready for public accountability.

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

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

**Measures and methods need to be updated to address gaps and inconsistencies.**

Our paper presents a first look at opportunities for integration of health literacy, cultural competence and communication and language assistance. The examples of measures provided is not meant to be exhaustive, but rather to be illustrative. It is possible that we may have missed important measures, or mis-classified some. In addition, there may be other, better ways to conceptualize the domains common across these concepts. A multi-stakeholder process, involving representatives of patients with different cultural perspectives and language needs, payers and representatives of different components of the health care system is needed to vet and fully develop these ideas. Indeed, all our recommendations depend on the active engagement of payers, who drive performance through payment incentives. Although CMS has indicated its interest in patient-centered care in the National Quality Strategy, and in health equity through its Measure Development Plan, drafted to comply with MACRA, the approach to adapting and updating measures needs to create alignment across multiple payers and different levels of the healthcare system – practices, hospitals, network, and health plans. Measurement should be implemented in the context of accountability programs.
Conclusion

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

Exhibits
## Exhibit 1. Definitions

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>Definition</th>
<th>Author/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Literacy</td>
<td>The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.</td>
<td>Institute of Medicine (IOM). (2004). <em>Health Literacy: A Prescription to End Confusion</em>.</td>
</tr>
<tr>
<td>Patient-Centered</td>
<td>Care that is respectful of and responsive to individual preferences, needs, and values, and ensuring that patient values guide all clinical decisions.</td>
<td>Institute of Medicine, Committee on Quality of Health Care in America. (2001.). <em>Crossing the Quality Chasm: A New Health System for the 21st Century</em>.</td>
</tr>
</tbody>
</table>
### Exhibit 2. Integrated, Patient-Centered Framework

| Organization culture and values | CLAS Standard 2: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources. | Health Literacy | Language | Patient-Centered Care |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
|                                 | • Provide incentives to encourage employees to use good communication practices. | • Health care system need to be more proactive and take responsibility to meet the needs of the people it serves by reducing the health literacy demands placed on individuals. |                                                          | • The patient-centered medical home fosters an environment of trust and respect. |
|                                 | • Health care system need to be more proactive and take responsibility to meet the needs of the people it serves by reducing the health literacy demands placed on individuals. |                                                          |                                                          | • Patient-centered care includes an interdisciplinary care team, which is led by a qualified provider of the patient’s choice, who guides care in a continuous, accessible, comprehensive and coordinated manner |
| Accountability and Quality Improvement | CLAS Standard 10: Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities. | • Employ monitoring and accountability for health literacy policies and practices. |                                                          | • Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. |
|                                 | • Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. |                                                          |                                                          | • Patients and families participate in quality improvement activities at the practice level |
|                                 | • Patients and families participate in quality improvement activities at the practice level | • Routinely undertakes efforts to identify and eliminate any disparities in the quality of care received by its patients. |                                                          | • Routinely undertakes efforts to identify and eliminate any disparities in the quality of care received by its patients. |
|                                 | • Routinely undertakes efforts to identify and eliminate any disparities in the quality of care received by its patients. |                                                          |                                                          | • Routinely undertakes efforts to identify and eliminate any disparities in the quality of care received by its patients. |

1. CLAS Standard 2
2. CLAS Standard 10
3. CLAS Standard 11
4. CLAS Standard 15
| Workforce | CLAS Standard 3: Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area. | Support changes to improve public health professionals’ health literacy skills. | Supports the language assistance needs of current and potential customers to inform policy and processes necessary to implement language assistance services that increase access to programs and services for all populations. | Training physicians to be more mindful, informative, and empathetic transforms their role from one characterized by authority to one that has the goals of partnership, solidarity, empathy, and collaboration. |
| Assessment | CLAS Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. | Health literacy assessment should be a part of healthcare information systems and quality data collection. | Collects data on race, ethnicity, sex, primary language, and language services for each patient and records that information in a manner that can be reported and used to plan and respond to the health and language needs of patients in the practice. |
| Community | CLAS Standard 12: Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. | Consider the current literacy level of the intended audience, and design messages based on that level. | Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic needs. |
| Community Engagement | CLAS Standard 13: Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness. | • Involve representatives from your target audiences in planning, implementing, disseminating, and evaluating health information and services.  
• Develop key partnerships to help facilitate change, influence behavior and generate interest in health literacy.  
• Develop partnerships with local programs and institutions that improve quality and access to services, strengthen systems, and formulate effective policies. This includes fostering broad, interdisciplinary approaches to health literacy.  
• Relevant stakeholders—patients, their families, clinicians, and health systems—should be involved in developing a family of measures to capture important aspects of patient-centered care; doing so will also provide an opportunity to align stakeholders’ perspectives on what counts as patient-centered care and how it should be accomplished.  
• Collaborates with patient and family advisors in quality improvement and practice redesign. | |
| Communication Materials | CLAS Standard 8: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. | • Present health information in varied forms/ mediums or written in clear, everyday terms so that people can take needed action.  
• Use plain language, including key elements  
• Supplement instructions with pictures.  
• Make written communication look easy to read  
• Improve the usability of information on the Internet | |
<table>
<thead>
<tr>
<th>CLAS Standards</th>
<th>Health Literacy</th>
<th>Language</th>
<th>Patient-Centered Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>•Consider the communication capacities of the intended users, including those with communication disorders/challenges; tailor communication strategies to their needs and abilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>•Consider the current literacy level of the intended audience, and design messages based on that level</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>•Be sure the materials and messages reflect the age, social and cultural diversity, language, and literacy skills of the intended users. Consider economic contexts, access to services, and life experiences.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral</td>
<td><strong>CLAS Standard 6</strong>: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.¹</td>
<td>•Health practitioners communicate clearly during all interactions with their patients, using everyday vocabulary ⁴</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CLAS Standard 5</strong>: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.¹</td>
<td>•Avoid jargon and explain technical or medical terms.⁵</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>•Ask open-ended questions, instead of those that can be answered with “yes” or “no.”⁶</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>•Use the “teach-back” method to ensure that the message is understood and remembered.⁶</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>•Ensure health information and services are appropriate,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>•Information and education to facilitate autonomy, self-care and health promotion⁸</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>•A more active invitation for involvement.¹⁰</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>•Tailored [communication] to patients’ needs to permit meaningful deliberation and shared mind¹⁰</td>
<td></td>
</tr>
</tbody>
</table>
| Patient Engagement | CLAS Standard 1: Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.¹ | Patients should receive care whenever they need it and in many forms, not just face-to-face visits.⁴  
• Provide health information in a manner appropriate to the audience.⁴  
• Allow ample time for discussions between patients and healthcare providers. ⁴  
• Patients feel free and comfortable to ask questions as part of the healing relationship⁴ | • Acknowledge patients as persons in context of their own social worlds, listened to, informed, respected, and involved in their care—and their wishes are honored (but not mindlessly enacted)¹⁰  
• [Provide] Emotional support and alleviation of fear and anxiety.⁸  
• Caregivers Patient-centered care considers both the art of generalizations and the science of particulars.¹⁰  
• The PCMH “knows” its patients and provides care that is whole-person oriented and consistent with patients’ unique needs and preferences.¹²  
• Patients and clinicians are partners in making treatment decisions.¹² |

### Sources


### Exhibit 3. Structure Measures

<table>
<thead>
<tr>
<th>Structure Measures</th>
<th>Domains of Integrated Patient-Centered Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Organization culture/values</td>
</tr>
<tr>
<td>Staff and Patient surveys</td>
<td>• Leadership commitment</td>
</tr>
<tr>
<td>Communication Climate Assessment Toolkit (C-CAT)</td>
<td>• Leadership commitment</td>
</tr>
<tr>
<td>Organization survey</td>
<td>• Leadership</td>
</tr>
<tr>
<td>Cultural Competency Implementation Measure (RAND)</td>
<td>• Leadership</td>
</tr>
<tr>
<td>Accreditation</td>
<td>• Use data and information in decision making</td>
</tr>
<tr>
<td>Structure Measures</td>
<td>Organization</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Health plan accreditation (NCQA)</td>
<td>• QI program description specifies objectives for serving a culturally and linguistically diverse population</td>
</tr>
</tbody>
</table>
## Structure Measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Organization culture/values</th>
<th>Accountability/QI</th>
<th>Workforce</th>
<th>Community Engagement</th>
<th>Assessment</th>
<th>Communication</th>
<th>Patient engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>community resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multicultural healthcare distinction (NCQA)</td>
<td>• Program description includes objectives for serving a culturally diverse membership</td>
<td>• Lists measurable goals for improving CLAS and reducing disparities</td>
<td>• Uses competent interpreter or bilingual services</td>
<td>• Has a process to involve the diverse community in QI</td>
<td>• Collects data on race/ethnicity and language needs of individuals and of community</td>
<td>• Translates vital documents into threshold languages</td>
<td>• Provides timely and competent</td>
</tr>
<tr>
<td>Structure Measures</td>
<td>Organization culture/values</td>
<td>Accountability/QI</td>
<td>Workforce</td>
<td>Community Engagement</td>
<td>Assessment</td>
<td>Communication</td>
<td>Patient engagement</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------</td>
<td>-------------------</td>
<td>-----------</td>
<td>---------------------</td>
<td>------------</td>
<td>--------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td>experience with language services • Evaluates the effectiveness of interventions to improve CLAS and reduce disparities • Reports HEDIS Diversity of Membership measures • Analyzes the capacity of the network to meet the cultural and language needs of the membership</td>
<td>language services</td>
<td></td>
<td></td>
<td></td>
<td>interpreter or bilingual services • Collects and publishes information about practitioner languages and language services • Supports practitioners in providing language services • Provides notice of the availability of language services in appropriate languages</td>
<td></td>
</tr>
</tbody>
</table>

**Primary care practices (NCQA Patient-Centered Medical Home 2017)**

- Clinician and leadership supports the PCMH model
- Communicates and engages patients on the medical home.
- Identifies disparities in care; implements actions to reduce the disparity;
- Stratifies performance data by race and ethnicity or by other indicators (e.g., age, gender, language needs, education, income, type of insurance,)
- Builds a health-literate organization (e.g., apply universal precautions, provide health literacy training for staff, system redesign to serve patients at different health literacy levels;
- Acts to establish processes that address health
- Involves patients and families in governance and QI
- Uses information on the population served by the practice to prioritize needed community resources.
- The practice maintains a community resource list by selecting five
- Collects information on how patients identify, e.g., race, ethnicity, and other aspects of diversity such as, gender identity, sexual orientation, religion, occupation, geographic residence.
- Demonstrates an understanding of the patients’ communication needs
- Uses patient-centered methods, such as open-ended questions (i.e., Teach-Back, collaborative method).
- Develops patient care plans for the patients identified for care management.
- Works with patients/families/caregivers to incorporate patient preferences and functional lifestyle goals in the care plan.
- Addresses barriers
<table>
<thead>
<tr>
<th>Structure Measures</th>
<th>Organization culture/values</th>
<th>Accountability/QI</th>
<th>Workforce</th>
<th>Community Engagement</th>
<th>Assessment</th>
<th>Communication</th>
<th>Patient engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify a vulnerable group in their patient population where there is evidence of disparities;</td>
<td>disability, health status).</td>
<td>literacy to improve patient outcomes.</td>
<td>topics or community service areas of importance to the patient population.</td>
<td>Documents language needs in its records</td>
<td>• Works with patients/families/caregivers to develop self-management instructions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sets goals and acts to improve performance.</td>
<td>Educates staff on how to interact effectively with people of different cultures.</td>
<td>• Demonstrates the ability to assess data and address identified gaps using community partnerships, self-management resources or other tools to serve the ongoing needs of its population.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Program requirements**

**Medicare Merit-Based Incentive Payment System (MIPS)**

**Improvement Activities**

**Related:**

- Leveraging a QCDR for use of standard questionnaire [for reducing disparities]
- Implementation of formal quality improvement methods, practice changes or other practice improvement processes

**Related**

- Engagement of community for health status improvement
- Practice improvements that engage community resources to support patient health goals
- Regular review practices in place on targeted

- Leveraging a QCDR to standardize processes for screening [for social determinants]

- Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities

- Engagement of new Medicaid patients and follow-up
- Improved practices that disseminate appropriate self-management materials [address literacy, language]
- Leveraging a QCDR to
<table>
<thead>
<tr>
<th>Structure Measures</th>
<th>Organization culture/values</th>
<th>Accountability/QI</th>
<th>Workforce</th>
<th>Community Engagement</th>
<th>Assessment</th>
<th>Communication</th>
<th>Patient engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participation in CAHPS or other supplemental questionnaire [like cultural competence]</td>
<td></td>
<td></td>
<td>patient population needs</td>
<td>Use of toolsets or other resources to close healthcare disparities across communities</td>
<td></td>
<td>promote use of patient-reported outcome tools</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Engagement of patients, family and caregivers in developing a plan of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Evidenced-based techniques to promote self-management into usual care</td>
<td></td>
</tr>
</tbody>
</table>
### Exhibit 4. Process Measures

<table>
<thead>
<tr>
<th>Target Entity</th>
<th>Measures</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health plan/prescription drug plan</td>
<td>Percent of time that TTY services and foreign language interpretation were available when needed by prospective members who called the plan’s prospective enrollee customer service phone number.</td>
<td>CMS Star Ratings</td>
</tr>
<tr>
<td>Hospital</td>
<td>The percentage of limited English proficient patients receiving both initial assessment and discharge instructions supported by interpreters who are assessed and trained or from bilingual providers and bilingual workers/employees assessed for language proficiency.</td>
<td>George Washington University School of Public Health and Health Services</td>
</tr>
<tr>
<td>Hospital</td>
<td>The percentage of patient visits and admissions where preferred spoken language for health care is screened and recorded.</td>
<td>George Washington University School of Public Health and Health Services</td>
</tr>
<tr>
<td>Medical group</td>
<td>Stable coronary artery disease: percentage of patients with stable coronary artery disease who have demonstrated an understanding of how to respond in an acute cardiac event by “teaching back” as to how they would respond in the case of acute cardiac event.</td>
<td>Institute for Clinical Systems Improvement</td>
</tr>
</tbody>
</table>
### Exhibit 5. Patient Experience Measures

<table>
<thead>
<tr>
<th>Topic</th>
<th>Cultural Competence</th>
<th>Health Literacy</th>
<th>Patient-Centered Medical Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Tests</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Forms</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Interpreters</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complementary &amp; alternative medicine</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Experiences of discrimination</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-management support</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Shared decision-making</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Provider knowledge of specialist care</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Access</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Content</td>
<td>Examples</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common to Health Literacy &amp; Cultural Competence</td>
<td>HL2/CU2. How often did this provider use medical words you did not understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HL3/CU3. How often did this provider talk too fast when talking with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HL17/CU8. How often did this provider use a condescending, sarcastic, or rude tone or manner with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Literacy</td>
<td>HL 4: How often did this provider use pictures, drawings, models, or videos to explain things to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HL14. How often did this provider ask you to describe how you were going to follow these instructions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HL30. In the last 12 months, how often were you offered help to fill out a form at this provider’s office?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Competence</td>
<td>CU17. In the last 12 months, did you feel you could trust this provider with your medical care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CU20. In the last 12 months, did you feel this provider really cared about you as a person?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CU14. In the last 12 months, how often have you been treated unfairly at this provider’s office because of your race or ethnicity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CU24. In the last 12 months, how often were you treated unfairly at this provider’s office because you did not speak English very well?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CU26. In the last 12 months, did anyone in this provider’s office let you know that an interpreter was available free of charge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CU32. Did any of your appointments start late because you had to wait for an interpreter?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>