

# **CLAS Draft Standards**



## DT 1: Data Collection

The organization gathers member race/ethnicity and language data using standardized methods.

### Intent

The organization collects information that helps it provide culturally and linguistically appropriate services.

### Element A: Direct Data on Race/Ethnicity

The organization:

1. Collects race/ethnicity data using direct data collection methods
2. Obtains and improves data from third-party sources
3. Has data on at least 25 percent of members, or 85 percent of members if data are obtained from third-party sources.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets no factors

**Data source** Reports, Materials, Documented process

**Scope of review**

**Look-back period**

**Explanation** Though it is voluntary for members to report their race/ethnicity, the organization must attempt to collect it. The organization may collect data directly at various points of interaction with members and through multiple mechanisms. While the organization should use as many channels as possible to collect race/ethnicity information from members, it may determine the appropriate timing of such data collection, to avoid concerns about discrimination in underwriting.

For full credit, the organization must employ the following standard direct data collection method and have data on at least:

- 25 percent of its members, **or**
- 85 percent of its members, if data are obtained from third-party sources.

**Direct data collection method**

**Direct data collection** is asking members or their caregivers for their race/ethnicity information. The organization must collect data using a uniform framework that includes:

- Use of Office of Management and Budget (OMB) race/ethnicity categories, at a minimum
- A script for staff who collect race/ethnicity.

### Office of Management and Budget categories

The organization must follow the OMB guidelines for collecting race/ethnicity. Although the OMB recommends a two-question format (asking for ethnicity before race), the organization may also use the OMB combined format. If more granular subcategories of race or ethnicity are used, the organization must have a consistent process to aggregate these responses into the OMB categories.

#### OMB two-question format

##### *Ethnicity*

- Hispanic or Latino
- Not Hispanic or Latino
- (Declined)

##### *Race*

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- (Declined)

##### *OMB combined format*

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- (Declined)

#### ***Declined vs Unavailable or Unknown***

In cases where member information is unknown due to active member refusal to respond to questions on race/ethnicity, the organization should label this response *Declined* and may count the response as having information on the member.

In cases where member information is unknown for any other reason, the organization should label this response *Unavailable or Unknown* and may not count the response as having information on the member.

#### **Survey responses**

In cases where the member is responding to a survey that includes questions in addition to a question on race/ethnicity:

- If the member responds to at least 80 percent of survey questions and leaves race/ethnicity blank, the organization should label the response as *Declined* and may count this response as having information on the member
- If the member responds to less than 80 percent of survey questions and leaves race/ethnicity blank, the organization should label this response as *Unavailable or Unknown* and may not count the response as having information on the member.

**Data Collection Systems**

Systems of data collection:

- Process for asking
- Data collection systems are electronic databases capable of receiving and storing member-level information on race/ethnicity.

**Data from third-party sources**

The organization may draw data from third-party sources, if these sources have directly asked for race/ethnicity from members or caregivers. For full credit, the organization must be able to categorize the data received, using the Office of Management and Budget framework, and have a process for assessing and improving data quality.

**Examples****Direct data collection mechanisms**

- Included on enrollment forms
- Through the organization's Web site
- Through member surveys
- During other contacts with the organization, such as calls to Member Services
- During intake for disease management or other programs involving enrollment or registration
- During health risk assessments

**Framework for asking about race/ethnicity**

The HRET Toolkit, endorsed by the National Quality Forum (NQF), provides detailed instructions for direct data collection of race/ethnicity data and may serve as a guide for how to ask members about race/ethnicity. The toolkit uses the OMB categories, with additional options, including *Declined* and *Multiracial*.

**Third-party sources of direct data**

- Employers
- State Medicaid agencies
- State or federal agencies, such as the Centers for Medicare & Medicaid Services (CMS)
- Health care providers
- Health care practitioners

## Element B: Direct Data on Language

The organization has language data on its members, collected using direct data collection methods.

Scoring	100%	80%	50%	20%	0%
	The organization has language data on at least 25% of its members	The organization has language data on at least 15% of its members	The organization has language data on at least 10% of its members	The organization has language data on at least 5% of its members	The organization does not have language data on its members

**Data source** Reports, Materials

**Scope of review**

**Look-back period**

**Explanation** Though it is voluntary for members to report their language preference, the organization must attempt to collect it. The organization may collect data directly at various points of interaction with members and through multiple mechanisms. While the organization should use as many channels as possible to collect language information from members, it may determine the appropriate timing of such data collection, to avoid concerns about discrimination in underwriting. For full credit on this element, the organization must have data on at least 25 percent of its total membership and employ the following direct data collection method.

**Direct data collection:** The organization asks members or their caregivers for their language information. The organization must collect data using a uniform framework that includes a script for staff to use.

Data may be drawn from third-party sources in the following circumstances.

- Sources have directly collected language information from members
- The organization has a process for assessing and improving data quality

### Direct data collection categories

Any question assessing a member's language preferences or needs is acceptable to satisfy the element. Members may choose a language from a list of languages, as long as the list includes the 10 most prevalent languages spoken in the Census region from which the membership is drawn. Alternatively, members may be asked to specify a language.

While the present standard does not prescribe how the organization requests language information, NCQA may designate a specific question in future standards, as evidence becomes available.

### Declined vs Unavailable or Unknown

In cases where member information is unknown due to active member refusal to respond to questions on language, the organization should label the response as *Declined* and may count the response as having information on the member.

In cases where member information is unknown for any other reason, the organization should label the response as *Unavailable or Unknown* and may not count the response as having information on the member.

**Exceptions** Where state requirements for data collection differ from those specified, satisfaction of state requirements for the relevant population satisfies this element. The organization must show documentation that it has satisfied state requirements.

**Examples****Types of questions on language**

- What is your preferred written language? [CA regulations]
- What is your preferred spoken language? [CA regulations]
- Would you like an interpreter? (*Response choices:* Yes, No, Do Not Know, Declined) [HRET Toolkit]
- In what language would you prefer to receive your care? [Speaking Together program]
- In which language would you feel most comfortable reading medical or health care instructions? [HRET Toolkit]

**Direct data collection mechanisms**

- Asking on the enrollment form
- Asking through the organization's Web site
- Asking through member surveys
- Asking during other contacts with the organization, such as calls to Member Services
- Asking during intake for Disease Management or other programs involving enrollment or registration

**Other sources of direct data**

- State and federal governments
- Government agencies, such as CMS
- Employers

**Framework for asking about language**

The HRET Toolkit, endorsed by the NQF, provides detailed instructions for direct collection of language data.

### Element C: Indirect Data on Race/Ethnicity

The organization's indirect methods to assess the race/ethnicity of its member population include the following.

1. Assignment of race/ethnicity for individual members by using geocoding at or below the U.S. Census tract level
2. Assignment of race/ethnicity for individual members by using surname analysis
3. Assessment of the validity of the methodology used to identify the race/ethnicity of the service area

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets no factors

**Data source** Reports, Materials, Documented process

**Scope of review**

**Look-back period**

**Explanation** While asking members to self-identify race/ethnicity is preferred, initial efforts may yield results on only a small percentage of members. Thus, indirect data collection may be necessary to understand the race/ethnicity of the entire member population for use in planning and evaluation. While these data can be used for planning and evaluation purposes, they should not be used for direct outreach to members.

#### Indirect data collection methods

**Geocoding** is the use of an individual's home address to infer other information, including race/ethnicity.

**Surname analysis** is the use of an individual's last name to infer other information, including race/ethnicity.

#### Validation of methodology used

While both geocoding and surname analysis methods can be accurate, their accuracy varies by geographic region, the demographics of the area and different race/ethnicity categories. For example, surname analysis tends to be more accurate in the identification of Hispanic ethnicity, while geocoding tends to be more accurate in the identification of African American race—and the two methods in conjunction have been shown to be more accurate than either method alone. Hence, an organization using indirect data collection methods must assess their ability to estimate the race/ethnicity distribution of members in its service area accurately. The relevant service area corresponds to that of the accreditable entity.

The organization must assess the sensitivity, specificity and positive predictive value of the methods used by comparing a sample of data collected through indirect methods with data collected directly from members. The organization may refer to studies conducted by other organizations if the studies assess the sensitivity, specificity and positive predictive value for the population in the relevant service area.

**Examples** None.

**Element D: Assessment of Language Needs**

The organization assesses the language needs of its members in the following ways.

1. Through internal monitoring of language services
2. By obtaining information on the languages of its members using direct or indirect data collection

Scoring	100%	80%	50%	20%	0%
	The organization meets both factors	No scoring option	The organization meets 1 factor	No scoring option	The organization does not meet either factor

**Data source** Reports, Documented process

**Scope of review**

**Look-back period**

**Explanation** The organization must determine the language needs of its members to develop a language services program that meets members' needs.

**Languages services** are bilingual services, oral interpretation and written translation.

**Internal monitoring**

The organization should keep track of languages encountered while carrying out organizational functions in order to understand its language-service needs.

**Direct data collection:** The organization asks members or their caregivers for their language information. The organization must collect data using a uniform framework that includes a script for staff to use.

Data may be drawn from third-party sources in the following circumstances.

- Sources have directly collected language information from members
- The organization has a process for assessing and improving data quality

**Indirect data collection methods**

**Geocoding** is the use of an individual's home address to infer other information, including language.

**Surname analysis** is the use of an individual's last name to infer other information, including language.

**Validation of methodology used**

While both geocoding and surname analysis methods can be accurate, their accuracy varies by geographic region, the demographics of the area and different languages. The two methods in conjunction have been shown to be more accurate than either method alone. Hence, an organization using indirect data collection methods must assess the methodology's ability for accurate estimation of the language of its members.

The organization must assess the sensitivity, specificity and positive predictive value of the methods used by comparing a sample of data collected through indirect methods with data collected directly from members. The organization may refer to studies conducted by other organizations if the studies assess the sensitivity, specificity and positive predictive value for the population in the relevant service area.

**Examples**

**Internal monitoring**

- Member requests for translated materials
- Member requests for interpreters
- Information from employers or employer groups
- Information from health care providers

## DT 2: Data Policies and Protection

The organization has systems in place to protect the confidentiality and facilitate the proper use of race/ethnicity and language data.

### Intent

The organization protects members' information from improper disclosure and use.

### Element A: Policies and Procedures

The organization has policies and procedures for managing access to and use of race/ethnicity and language data that address:

1. Controls for physical and electronic access to the data
2. Permissible uses of the data
3. Impermissible uses of the data, including underwriting and denial of coverage and benefits
4. Actions that may be taken in the event of a breach of policy

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets at least 3 factors	The organization meets at least 2 factors	The organization meets 1 factor	The organization meets no factors

**Data source** Documented process

**Scope of review**

**Explanation** **Access to data**

The organization has documented processes to govern and track the receipt, removal and access to devices and media that contain member-level race/ethnicity and language data or which may be used to access these data. The documented process covers media, devices and hardware movement, data storage, disposal and re-use of media and devices.

**Media**

- Diskettes, CDs and tapes
- Portable drives
- Laptops
- Secure portals

To minimize the risk of impermissible access to sensitive information, the organization has a process to limit access to employees whose jobs require it, and to terminate access by employees who are no longer authorized to access the data.

**Permissible and impermissible uses**

The organization outlines permissible and impermissible uses of the data. Impermissible uses explicitly include underwriting and denial of coverage and benefits.

**Actions taken in the event of a breach of policy**

The organization outlines what steps will be taken in the event data are inappropriately accessed, disclosed or used.

**Examples**

**Permissible uses of data**

- To assess health care disparities
- To design intervention programs
- To design outreach materials

**Element B: Disclosure to Members**

Upon direct data collection and annually thereafter, the organization informs members of its policies and procedures regarding member race/ethnicity and language data in all threshold languages and in other languages on request. Communication includes:

1. The organization’s routine use and disclosure of race/ethnicity and language data
2. Internal protection of oral, written and electronic data across the organization
3. Prohibition of use of data for underwriting and denial of coverage and benefits.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	No scoring option	The organization meets 1-2 factors	No scoring option	The organization meets no factors

**Data source** Reports, Materials, Documented process

**Scope of review**

**Look-back period**

**Explanation** The organization must communicate to members its policies that address all requirements covered in Element A and how they are implemented. Communication must be provided at the time of direct data collection and annually thereafter. Information must be provided in all threshold languages and any in other language on request. The organization may provide notification as a multilingual notice that includes all threshold languages or a notice targeted to the individual member in the member’s threshold language.

**Threshold languages** are defined as follows.

- *For organizations with enrollment of 1,000,000 or more:* The top two languages other than English, as determined by either direct or indirect data collection, and any additional languages, when 0.75 percent of the member population or 15,000 members, whichever number is less, indicates a preference for written materials in that language.
- *For organizations with enrollment of 300,000 or more but less than 1,000,000:* The top language other than English, as determined by either direct or indirect data collection, and any additional languages, when 1 percent of the member population or 6,000 members, whichever number is less, indicates a preference for written materials in that language.
- *For organizations with enrollment of less than 300,000:* Any language, as determined by either direct or indirect data collection, when 5 percent of the member population or 3,000 members, whichever number is less, indicate a preference for written materials in that language.

Refer to *LA 1: Access and Availability of Language Services*, Element A for appropriate turnaround times for requests for materials in languages other than threshold languages.

**Examples** Annual disclosure of direct data collection may occur during annual privacy policy disclosures.

## LA 1: Access and Availability of Language Services

The organization provides materials and services in the languages of its membership.

### Intent

The organization effectively communicates with its members.

### Element A: Written Documents

For written documents, the organization:

1. Translates vital documents into all threshold languages
2. Translates vital documents into non-threshold languages on request
3. Provides oral interpretation of vital documents for non-threshold languages on request
4. Provides in-language versions and translates or provides oral interpretation of non-vital documents into non-threshold languages on request
5. Requires all translations and in-language versions to be created using competent translation services
6. Implements a process, with specified turnaround times, to distribute translated versions of documents.

### Scoring

100%	80%	50%	20%	0%
The organization meets all 6 factors	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets no factors

**Data source** Reports, Materials, Documented process

### Scope of review

**Explanation** For vital documents, the organization must

- Translate vital documents into all threshold languages and distribute them to members who prefer written communication in a language other than English. The organization may distribute multi-lingual versions of vital documents to all members, or distribute different language versions according to individual language needs.
- Provide oral interpretation of vital documents for non-threshold languages on request.

For non-vital documents, the organization must provide in-language versions or translated versions, or provide oral interpretation of these documents on request.

**Threshold languages** are defined as follows:

- *For organizations with enrollment of 1,000,000 or more:* The top two languages other than English, as determined by either direct or indirect data collection, and any additional languages, when 0.75 percent of the member population or 15,000 members, whichever number is less, indicates a preference for written materials in that language.

- *For organizations with enrollment of 300,000 or more but less than 1,000,000:* The top language other than English, as determined by either direct or indirect data collection, and any additional languages, when 1 percent of the member population or 6,000 members, whichever number is less, indicates a preference for written materials in that language.
- *For organizations with enrollment of less than 300,000:* Any language, as determined by either direct or indirect data collection, when 5 percent of the member population or 3,000 members, whichever number is less, indicate a preference for written materials in that language.

**In-language materials** are documents that have been created in the target language, as opposed to being created in English and then translated to the target language.

#### **Vital documents**

A **vital document** contains information critical for obtaining or understanding services or benefits, or is required by law. The following are vital documents.

- Information provided to prospective members about benefits and services
- Letters containing information regarding eligibility and participation criteria
- Enrollment and disenrollment forms
- Evidence of coverage
- Member handbook, including, but not limited to, the following:
  - Provider listings
  - Primary care provider selection, auto-assignment and instructions for transferring to a different primary care provider, if applicable
  - Process for accessing covered services requiring prior authorizations
  - Information regarding the use of organization services including access to after-hours emergency and urgent care services
- Consent forms, as applicable to the organization
- Template notices pertaining to the denial, reduction, modification or termination of services and benefits, and the right to file a grievance or appeal (e.g., the portion of the notice that is standard and does not contain member-specific information)
- Notifications of practitioner termination
- Notification of drug recalls and withdrawals for patient safety reasons

#### **Competent translation services**

**Competent translation services** denote a trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language.

The organization must demonstrate the following to receive credit for providing competent translation services.

- *If the organization is using internal translation services*, it must demonstrate that translators have been assessed for proficiency in the source and target languages
- *If the organization is using external translation services*, it must obtain documentation from the service showing the same

**Turnaround times and distribution of translated versions**

The organization must follow a documented process to make translated versions of documents available to members who need materials in a language other than English. The process must specify turnaround times and may differentiate turnaround times for vital vs. non-vital documents, and for translations into threshold vs. other languages, as long as the process does not violate the limited-English-proficient member's rights or prevent the member from obtaining the organization's services.

**Exception**

Translation into threshold languages of Evidence of Benefits (EOB) is not required because of timing requirements for distribution, but members must receive notice of the availability of translated materials or oral interpretation services with the EOB.

**Examples**

**Competent translation services**

- Translation service employs American Translators Association certified translators

**Non-vital documents**

- Newsletters
- Outreach materials

**Distribution of translated versions**

Organizations that have detailed data on member language needs may automatically send translated documents to members for whom the organization has data indicating that the member requires written documents in a threshold language. Alternatively, or for members about whom the organization does not have information on language needs, the organization may include with vital documents a statement in all threshold languages advising members of the availability of translated versions, and the process for obtaining translated versions. The organization must have a process for promptly fulfilling such requests.

**Element B: Interpreter Services Organization**

For organization functions, the organization communicates with members by:

1. Using competent interpretation services for requested languages
2. Providing interpretation services or in-language access for automated incoming telephone encounters in threshold languages.

Scoring	100%	80%	50%	20%	0%
	The organization meets both factors	No scoring option	The organization meets 1 factor	No scoring option	The organization does not meet either factor

**Data source** Reports, Materials

**Scope of review**

**Explanation Competent interpreter services**

**Competent interpreter services** denote a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language, including sign language.

The organization may provide competent interpreter services directly through professional interpreters or bilingual staff; contracts with language service providers; or electronic media such as telephone language lines, video links and other remote systems. A **professional interpreter** is an individual paid and provided by the organization to interpret and who has completed training in interpretation. **Bilingual staff services** refer to staff who speak both English and the member's preferred language and who are trained to provide interpretation for organization functions.

The organization must demonstrate the following in order to receive credit for competent interpretation services.

- *If the organization is using internal interpreters or bilingual staff services*, it must demonstrate that these staff have been assessed for proficiency in the source and target languages, and have received training to interpret
- *If the organization is using external interpreter services*, it must obtain documentation from the service showing the same

**Organization functions**

**Organization functions** include any interaction a member is likely to have with the organization, either in person or over the telephone, including, but not limited to, the following.

- Member Services Department
- Claims
- Utilization management
- Disease management
- Case management
- Complaints, grievances and appeals

**Incoming automated telephone encounters** are telephone systems that direct members who initiated the call to press a button or speak into the telephone to access organization functions.

**Threshold languages** are defined as follows.

- *For organizations with enrollment of 1,000,000 or more:* The top two languages other than English, as determined by either direct or indirect data collection, and any additional languages, when 0.75 percent of the member population or 15,000 members, whichever number is less, indicates a preference for written materials in that language.
- *For organizations with enrollment of 300,000 or more but less than 1,000,000:* The top language other than English, as determined by either direct or indirect data collection, and any additional languages, when 1 percent of the member population or 6,000 members, whichever number is less, indicates a preference for written materials in that language.
- *For organizations with enrollment of less than 300,000:* Any language, as determined by either direct or indirect data collection, when 5 percent of the member population or 3,000 members, whichever number is less, indicate a preference for written materials in that language.

**Examples**

**Demonstrating language proficiency**

- Tests administered by the organization
- Tests administered by a contracted language service organization
- Grades or certification in interpretation issued by an accredited college or university or other entity

**Element C: Interpreter Services Health Care Encounter**

The organization facilitates the use of competent interpreter services at the time of the health care encounter by:

1. Sharing with practitioners data on language needs of the population in the service area
2. Providing practitioners language assistance tools
3. Offering training to practitioners on the provision of language services
4. Obtaining documentation from practitioners showing that practitioners have a process for delivering language services.

Scoring	100%	80%	50%	20%	0%
	The organization meets 3-4 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

**Data source** Reports, Materials, Documented process

**Scope of review**

**Explanation** A **health care encounter** is an outpatient visit to a clinical practitioner.

**Facilitating use of competent interpreter services during health care encounters**

The organization can facilitate the use of competent interpreter services at the time of the health care encounter in several ways. **Competent interpreter services** denote a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended. The following guidelines should be used to assess the competence of interpreter services.

- *If using internal interpreters or bilingual staff services*, staff have been assessed for proficiency in the source and target languages
- *If using external interpreter services*, documentation from the service shows that staff have been assessed for proficiency in the source and target languages

**Sharing language data with practitioners**

The organization shares with practitioners data about the language needs of its membership.

**Providing practitioners language assistance tools**

The organization distributes or makes available to practitioners electronic language assistance tools.

**Offering training to practitioners on the provision of language services**

The organization offers training to practitioners on how to identify and serve patients with limited English proficiency. The U.S. Office of Civil Rights defines a **limited-English proficient person** as “one who does not speak English as his/her primary language and who has a limited ability to read, speak, write, or understand English.” Limited-English proficient persons are defined by the U.S. Census Bureau as “anyone who answers less than *Very Well* to the U.S. Census question *How well do you speak English?*”

**Documentation from practitioners**

The organization obtains documentation from its practitioners showing that practitioners have a process for delivering language services.

**Examples**

**Language assistance tools**

- Language identification cards, such as “I Speak [Language]” cards
- Downloadable multilingual signage
- Translated patient education materials
- Web pages or resource directories identifying translation or health care interpretation services

**Offering training to practitioners on the provision of language services**

- Informing practitioners of the types of language services available
- Informing practitioners how staff can obtain those services
- Offering workshops, online tutorials, manuals or other written or in-person instruction to practitioners on how they or staff can respond to limited-English proficient callers
- Offering workshops, online tutorials, manuals or other written or in-person instruction to practitioners on how they or staff can respond to written communications from limited-English proficient persons
- Offering workshops, online tutorials, manuals or other written or in-person instruction to practitioners on how they or staff can respond to limited-English proficient individuals with whom they have in-person contact

**Element D: Notification of Language Services**

The organization distributes written notice about:

1. The availability of translation services in the 10 most frequently spoken languages in the service area
2. The availability of interpreter services for organization functions in the 10 most frequently spoken languages in the service area.

Scoring	100%	80%	50%	20%	0%
	The organization meets both factors	No scoring option	The organization meets 1 factor	No scoring option	The organization does not meet either factor

**Data source** Materials, Documented process

**Scope of review**

**Explanation** The organization informs all members of the availability of language services. The organization must provide written notice in the 10 most prevalent languages of the service area or region.

**Examples** Materials that may be used to inform members of language services include:

- Statements on vital documents
- Mailings
- Brochures
- Language identification cards, such as *I Speak...* cards

## LA 2: Evaluation of Language Services

The organization systematically evaluates the use of and experience with language services.

### Intent

The organization assesses the language services it provides to its members.

### Element A: Language Services Monitoring

At least annually, the organization monitors utilization or timeliness of language services for organization functions.

Scoring	100%	80%	50%	20%	0%
	The organization annually monitors its language services using at least 2 indicators	No scoring option	The organization annually monitors its language services using 1 indicator	No scoring option	The organization does not monitor its language services

**Data source** Reports

**Scope of review**

**Explanation** **Languages services** are bilingual services or oral interpretation, including sign language interpretation and written translation.

**Utilization** is the frequency or rate of service use.

**Timeliness** denotes target response time and percentage of cases meeting the pre-determined response time.

The organization may use one utilization and one timeliness indicator, or may use two indicators for either utilization or timeliness.

### Examples

#### Utilization indicators

- The percentage of members who request language services and who receive such services for organization functions
- The percentage of total members who used one or more language services
- The percentage of members whose primary language is not English and who used one or more language services

#### Timeliness indicators

- Telephone hold times for members requesting language services compared with members not requesting language services

**Element B: Evaluating Language Services Experience**

At least annually, the organization evaluates both member and staff experience with language services for organization functions.

Scoring	100%	80%	50%	20%	0%
	The organization evaluates member and staff experience using at least 1 indicator for each	No scoring option	The organization evaluates member experience using at least 1 indicator	No scoring option	The organization does not evaluate its language services

**Data source** Reports

**Scope of review**

**Explanation** The organization may use a variety of mechanisms, including quantitative or qualitative data, to meet this element. To the extent that the organization uses CAHPS® items or supplemental questions, it uses sampling methods appropriate to capture members who needed or used language services. The organization may solicit point-of-contact feedback, by survey or interview, and it may obtain feedback through the use of interviews, focus groups or other qualitative methods.

- Examples**
- Methods to evaluate member experience**
- Member survey (to all members, or to members who have indicated a language preference other than English, or to members who have used language services)
  - Follow-up calls to members who have requested or used language services
  - Evaluation questionnaire/interview administered at the point of service for members who have used language services
  - Focus groups with members or community advocates
- Methods to evaluate staff experience**
- Survey of front-line staff about their experience using language services
  - Analysis of rating forms completed by staff for each language service used
  - Focus groups/meetings with staff who use language services
- Indicators of member or staff experience**
- Member ratings of access to language services
  - Staff ratings of length of time it takes to obtain language services to aid them in serving members

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

**Element C: Evaluating Health Care Language Experience**

At least annually, the organization evaluates member experience with language services during health care encounters.

Scoring	100%	80%	50%	20%	0%
	The organization evaluates member experience using at least 2 indicators	No scoring option	The organization evaluates member experience using at least 1 indicator	No scoring option	The organization does not evaluate member experience

**Data source** Reports

**Scope of review**

**Explanation** A **health care encounter** is an outpatient visit to a clinical practitioner. The organization may use a variety of mechanisms, including quantitative or qualitative data, to meet this element. To the extent that the organization uses CAHPS items or supplemental questions, the organization uses sampling methods that are appropriate to capture members who needed or used language services. The organization may solicit point-of-contact feedback, by survey or interview, and it may obtain feedback through the use of interviews, focus groups or other qualitative methods.

**Examples** **Methods to evaluate member experience**

- Member survey (to all members, or to members who have indicated a language preference other than English, or to members who have used organization language services) to obtain feedback on their experience with language services in the clinical setting
- Follow-up calls to members who have requested or used organization language services to obtain feedback on their experience with language services in the clinical setting
- Evaluation questionnaire/interview administered at the point of service for members who have used language services about their experience with language services in the clinical setting.

**Indicators of member experience**

- Overall rating of interpretation services
- Access to language services at health care encounter

## DCC 1: Network Diversity

The organization maintains a network that reflects the diversity of its membership and is responsive to member needs and preferences.

### Intent

The organization maintains a practitioner network that can meet the cultural and linguistic needs of its members.

### Element A: Assessment of Practitioner Information

The organization collects the following practitioner characteristics and capabilities.

1. Languages in which the practitioner is comfortable providing medical care
2. Languages spoken in the office
3. Practitioner race/ethnicity

Scoring	100%	80%	50%	20%	0%
	The organization collects all 3 factors	The organization collects 2 factors	The organization collects one factor	No scoring option	The organization collects no factors

**Data source** Documented process, Reports

**Scope of review**

**Explanation** Some patients feel most comfortable with practitioners who share their language and racial/ethnic background. Patient/practitioner communication is enhanced when there is a common language and culture (Cooper 2003; Garcia 2003; Saha 2000; Street 2008). Although it may not be possible for the organization to establish a practitioner network that exactly matches the demographic profile of its membership, the organization facilitates high quality care by providing, to the extent possible, a choice of practitioners that includes all major racial/ethnic and linguistic groups represented by the membership.

#### Practitioner languages

The organization requests practitioner language information from all contracted network practitioners and identifies languages in which a practitioner is comfortable providing medical care.

#### Languages spoken in the office

The organization asks practitioners to specify languages in which patients may be effectively served and to which there is a commitment to maintaining availability of services in that language.

**Practitioner race/ethnicity**

The organization uses direct data collection methods to obtain practitioner race/ethnicity and language using the same categories used for member race/ethnicity and language. The organization may determine the appropriate timing of data collection, to avoid concerns about discrimination in contracting. The organization may obtain data on practitioner race/ethnicity and language from credentials verification organizations if the data were originally obtained by direct methods.

**Examples**

**Sources of practitioner race/ethnicity and language information**

- Practitioner survey
- Credentialing form
- Provider relations script

## Element B: Availability of Practitioner Information

The organization makes the following information available to members.

1. Practitioner languages
2. Languages spoken in the office

Scoring	100%	80%	50%	20%	0%
	The organization makes both factors available	The organization makes 1 factor available	No scoring option	No scoring option	The organization does not provide information to members

**Data source** Materials, Reports

**Scope of review**

**Explanation** The organization provides information about practitioner language capabilities, as well as languages spoken in the practitioner's office, on its Web site, in its provider directories or through Member Services staff. If the information is not in the provider directory but is available elsewhere (e.g., by contacting member services), the organization prominently places notice in the written or Web-based directory indicating how members may obtain the information.

For members who do not have Internet access, the organization makes information about practitioner and office languages available through means other than the Internet.

**Examples** **Making information available to members**

- Provider directories (written or Web-based)
- Web-based query function
- Resource list used by Member Services staff to answer member questions

### Element C: Enhancing Network Cultural Competence

The organization undertakes the following actions to support its network in meeting the needs of its membership.

1. Analyzes its network racial/ethnic and language composition relative to member needs
2. Develops a plan to address any gaps identified as a result of analysis, if applicable
3. Takes action based on its plan, if applicable

Scoring	100%	80%	50%	20%	0%
	The organization meets all applicable factors	The organization meets factor 1 and 1 of 2 additional applicable factors	The organization meets factor 1 and no other applicable factors	No scoring option	The organization meets no factors

**Data source** Materials, Reports

**Scope of review**

**Explanation** **Analyzing network composition**

The organization analyzes the needs of its members, using direct or indirect data about race/ethnicity and language, and compares membership demographics and language needs with network demographics and language capabilities.

The organization should analyze both its membership and its practitioner network by the geographic unit that reflects the health care utilization patterns of its service area so it can identify a shortage of practitioners of a specific ethnic/racial or linguistic group. Analysis should focus on the member population and the network composition. Comparing characteristics of the population in the service area with those of practitioners in the service area does not meet the intent of this element.

The organization must evaluate language separately from race/ethnicity. Membership race/ethnicity and language data may be either direct or indirect data, but must be tied to the specific members enrolled in the organization.

The organization must establish a method for determining whether gaps exist in the network. Where there are gaps (e.g., limited numbers of African American primary care physicians in a predominantly African American neighborhood or insufficient practitioners who speak a prevalent language), the organization develops and implements a plan to meet the needs of its members.

NCQA recognizes that in an environment in which there is a shortage of primary care practitioners, it is not practical to address gaps solely by recruiting additional practitioners with specific racial/ethnic or linguistic backgrounds—organizations must consider a variety of innovative approaches to meeting member needs. These may include use of community partnerships, such as faith-based communities, public health agencies or other community organizations; or other avenues, such as social networking.

#### Exceptions

Factors 2 and 3 are NA if the organization does not identify gaps in the network with respect to race/ethnicity and language.

**Examples****Analysis of network composition**

Within a relevant geographic subdivision (such as a county or a census tract), the organization might analyze the frequency of each race/ethnicity and language among its practitioners and compare that frequency with that identified for the members residing in the same area. Analysis could focus on race/ethnicity and language categories common among the membership; for example, reflected in at least 5 percent of members in a geographic area.

**Addressing gaps**

- Recruit and credential practitioners with specific language skills
- Recruit and credential practitioners with similar cultural and racial/ethnic background as underrepresented members
- Provide enhanced interpretation services for a specific language group or geographic area
- Encourage practitioners to complete additional or specific cultural competency training based on the racial/ethnic composition of the member population
- Engage community organizations and partners to extend the capabilities of the practitioner network to conduct outreach, health education and other important health communication
- Hire or direct practitioners to community health workers, advocates or patient navigators to assist members in their interactions with health care practitioners

## DCC 2: Cultural Competence

The organization demonstrates a commitment to cultural competence by establishing a plan and integrating cultural competence goals into routine management processes.

### Intent

The organization integrates cultural competence goals throughout its operations.

### Element A: Organizational Assessment

The organization conducts a written assessment that includes the following.

1. The extent to which cultural competence goals are reflected in its strategic plan
2. The extent to which cultural competence goals are integrated in its annual business plan
3. The cultural competence of its front-line staff
4. The extent to which cultural competence goals are reflected in agreements with network providers (facilities)
5. The extent to which cultural competence goals are reflected in agreements with network practitioners (clinicians)
6. The concordance between languages spoken by the membership and by its front-line staff

Scoring	100%	80%	50%	20%	0%
	The organization assesses 5-6 factors	The organization assesses 4 factors	The organization assesses 3 factors	The organization assesses 1-2 factor	The organization assesses no factors

**Data source** Reports

**Scope of review**

**Explanation** **Written assessment**

The organization documents its assessment of integrating cultural competence into routine management processes.

**Cultural competence** is defined by the Office of Minority Health 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. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.”

#### **Strategic plan**

A **strategic plan** is a long-term plan, usually with a three–five-year time horizon. Improving the provision of culturally and linguistically appropriate services and organizational cultural competence is a significant undertaking, requiring resources and focused attention. The organization’s long-term goals and milestones for providing and improving these services must be reflected in the strategic plan approved by the governing body.

### **Annual business plan**

A **business plan** is a one-year plan that specifies activities and projects that the organization intends to undertake in the coming year as a step toward implementing the strategic plan. The annual business plan identifies the short-term goals and milestones required to make progress toward the long-term goals outlined in the strategic plan, and the resources required to achieve them. The organization's current goals, milestones and required resources for improving culturally and linguistically appropriate services must be reflected in the current business plan approved by the governing body.

### **Cultural competence of front-line staff**

An assessment of staff cultural competence includes:

- Race/ethnicity
- Languages spoken
- Knowledge of the demographic profile of the service area
- Attitudes toward working with people from different cultures
- Awareness of how people from prevalent cultures in the service area interpret various actions and communication styles, such as eye contact, touching and interrupting
- Understanding of how to determine whether there are language or cultural barriers interfering with communication
- Skills in assessing understanding
- Knowledge of how to access language services
- Knowledge of and experience in working with an interpreter

### **Agreements with network providers**

Many of the organization's goals for cultural competence depend on the cooperation and collaboration of network providers. For example, the organization may set a goal for provider staff being trained in cultural competence or how to use language services. The organization may depend on network providers to help inform members of the availability of language services. Such goals may be met through inclusion in contracts or other agreements with network providers. The organization must clearly indicate in writing its expectations for the improvement of culturally and linguistically appropriate services.

### **Contracts with network practitioners**

The organization must clearly indicate in agreements with network practitioners its expectations for improving culturally and linguistically appropriate services, including practitioner and organization responsibilities and support the organization will provide to the practitioners.

### **Front-line staff**

**Front-line staff** are staff whose primary responsibilities involve interacting directly with members. These may include Member Services, claims and billing staff, disease management nurses, case management nurses, social workers, telephone advice nurses, some marketing representatives or others with responsibility for member contact. Assessment of language concordance between front-line staff and membership must include an assessment of languages spoken by all front-line staff, by department or function.

**Language concordance**

To assess language concordance between staff and membership, the organization may use information gathered in *DT 1: Data Collection*, Element B or Element D, to assess the language needs of the membership.

**Examples****Organizational assessments**

- Policy Brief 2—*Linguistic Competence in Primary Health Care Delivery Systems: Implications for Policy Makers*, National Center for Cultural Competence, Georgetown University Center for Child and Human Development, 2007.
- *Conducting a Cultural Competence Self Assessment*, Dennis Andrulis/SUNY/Downstate Medical Center, 2007.
- *Cultural and Linguistic Competence Policy Assessment*, National Center for Cultural Competence, Georgetown University Center for Child and Human Development, 2007.
- *Cultural Competence Resource for Health Care Providers, Chapter 7: Assessment and Evaluation*, Health Resources and Services Administration, U.S. Department of Health and Human Services.
- Cultural Competency Organizational Self Assessment Question Bank, The AIDS Education and Training Centers, Cultural Competence and Multicultural Care Workgroup coordinated by the AETC National Resource Center of the François Xavier Bagnoud Center of the University of Medicine and Dentistry of New Jersey, 2006.
- *Self Assessment for Cultural Competence, Policies and Procedures, Cultural Competence Checklist: Policies and Procedures* (n.d.). Available from the Web site of the American Speech-Language-Hearing Association <http://www.asha.org/about/leadership-projects/multicultural/self.htm>.

**Agreements with network providers**

- Provision for cultural competency training
- Collaboration on a quality improvement project targeted to improve care for racial/ethnic or linguistic minorities
- Provision for improvement of use of language services
- Provision for reporting to the organization on the quality of culturally and linguistically appropriate services

**Agreements with network practitioners**

- Requirements to disclose to patients the availability of language services
- Requirements to keep the organization updated on languages spoken by the practitioner and office staff
- Requirements to arrange for interpretation for encounters with patients whose English proficiency is limited and who request an interpreter
- Provision for participation in quality improvement projects focusing on care to racial, ethnic or linguistic minorities
- Support available from the organization, such as cultural competency training, access to the organization's language line, feedback from data analyses

## Element B: Enhancing Staff Cultural Competence

The organization takes action to improve the cultural competence of its front-line staff through the following.

1. Recruiting staff with specific language skills where gaps exist (if applicable)
2. Providing or requiring training in cultural competence awareness
3. Providing or requiring training in cross-cultural communication skills
4. Evaluating the effectiveness of training

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 applicable factors	The organization meets 3 applicable factors	The organization meets 2 applicable factors	The organization meets 1 applicable factor	The organization meets no applicable factors

**Data source** Materials, reports

**Scope of review**

**Explanation** **Front-line staff** are staff whose primary responsibilities involve interacting directly with members. These may include Member Services, claims and billing staff, disease management nurses, case management nurses, social workers, telephone advice nurses, some marketing representatives or others with responsibility for member contact.

### Recruiting staff with language skills

The organization must seek opportunities to improve the ability of front-line staff to provide culturally and linguistically appropriate services to its members. The organization need not implement hiring quotas, but it is appropriate for the organization to seek to employ staff who speak the same languages as the membership.

### Training in cultural competence awareness includes:

- The demographic profile of the service area and the organization's members
- Information about health care disparities
- Stereotyping and its effect on communication
- How people from different cultures interpret various actions and communication styles, such as eye contact, touching and interrupting

### Training in cross cultural communication skills

Cross cultural communication skills include, at a minimum, how to determine whether language or cultural barriers are interfering with communication, how to assess understanding and how to work with an interpreter.

### Evaluating training

- *For training provided directly*, the organization must either conduct pre- and post-tests to evaluate the effectiveness of the knowledge transfer resulting from training, or must seek feedback from trained staff after an interval following training, to assess its value in the context of their work.

- *For training obtained externally*, the organization must seek feedback from trained staff after an interval following training, to assess its value in the context of their work.

Factor 4 is applicable only if the organization meets either factor 2 or factor 3.

## Examples

### **Methods to recruit staff from specific groups**

- Placement of job announcements in specialized or niche publications or Web sites
- Placement of job announcements in the language sought
- Announcement to the membership of job opportunities
- Use of referral incentives for staff who refer job applicants
- Job requirement or preference for specific language skills

### **Training opportunities**

- New-employee orientation
- Special cultural competency training programs
- Cultural competency content integrated into existing training programs
- External programs

### **Documents that demonstrate compliance:**

- *For educational content provided by the organization*, the objectives and agenda for the program, which demonstrate the required training content
- *For content that the organization does not provide directly*, a documented process that indicates how the organization determines whether the content meets the requirements
- Self-assessment tools may be used to evaluate the effectiveness of training

## AQI 1: Culturally and Linguistically Appropriate Services Programs

The organization continually improves its culturally and linguistically appropriate services.

### Intent

The organization improves care and services for all its members.

### Element A: Program Structure

The organization has a program description for improving culturally and linguistically appropriate services that includes the following.

1. A written statement describing the organization’s overall objective for serving a culturally and linguistically diverse membership, if applicable
2. A process to involve members of the minority community in identifying and prioritizing opportunities for improvement
3. A list of measurable goals for the improvement of culturally and linguistically appropriate services and reduction of health care disparities
4. An annual work plan
5. A plan for monitoring against the goals
6. Approval by the governing body

Scoring	100%	80%	50%	20%	0%
	The organization meets all 6 factors	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

**Data source** Documented process

**Scope of review**

**Explanation** **Culturally and linguistically appropriate services**

The Office of Minority Health defines culturally and linguistically appropriate services as, “health care services that are respectful of and responsive to cultural and linguistic needs.”

**Program structure**

A **program structure** is a formal decision-making arrangement wherein an organization’s goals and objectives are identified, grouped and coordinated in an operational framework. The culturally and linguistically appropriate services program structure may be independent or it may be integrated within the organization’s quality improvement (QI) program. the structure defines how the organization uses its resources to achieve its goals and must include the following information.

- How the culturally and linguistically appropriate services program is organized to meet program objectives
- Functional areas and their responsibilities
- Reporting relationship for staff involved in providing culturally and linguistically appropriate services

### **Written document**

The culturally and linguistically appropriate services program description must be organized and written so that staff members can understand the program's goals, objectives and structure. The program description may be an independent document or it may be integrated within the QI program description.

### **Process to involve members of the minority community**

The culturally and linguistically appropriate services program obtains input and participation from the community served, to ensure that it meets the needs of the population—simply including a community representative on the program team does not meet the intent of the element. Community representatives should not be practitioners, and should include, but they need not be limited to, members and clients of the organization.

### **List of measurable goals**

The organization must articulate one or more goals for provision of culturally and linguistically appropriate services in its program description. Goals should reflect the demographics of the community, known or suspected needs of the membership and previously identified opportunities for improvement, and must be specific, measurable, achievable, reasonable and time-bound.

### **Work plan**

The culturally and linguistically appropriate services work plan may be a separate document or it may be included in the culturally and linguistically appropriate services program description, the QI program description or the QI work plan, and must address the following.

- Organizational cultural competence
- Network cultural competence
- Language services
- Program scope
- Yearly objectives
- Yearly planned activities
- Time frame within which each activity is to be achieved
- The staff member responsible for each activity
- Monitoring previously identified issues
- Evaluation of the culturally and linguistically appropriate services program

The work plan can be as simple as a calendar of events scheduled for the year, a Gantt chart that shows planned activity or a brief text that includes the planned period for each activity. It is a dynamic document that the organization updates frequently to reflect progress on culturally and linguistically appropriate services activities throughout the year.

### **Monitoring against goals**

The organization must indicate how it will monitor progress against its goals, including what measures will be collected, how frequently they will be monitored and who will review and sign off on monitoring reports.

**Approval by the governing body**

The **governing body** is the organization's board of directors, which is responsible for organizational governance. In instances where its participation in QI or culturally and linguistically appropriate services activities is indirect, the board may designate a subcommittee or the organization's management staff (external to the QI Committee) to oversee culturally and linguistically appropriate services activities.

The culturally and linguistically appropriate services program description must contain documentation of the subcommittee's accountability to the governing body. The governing body must review and approve the program description annually.

**Examples**

**Members of the minority community**

- Members/patients from cultural or linguistic minority groups
- Community advocates
- Employers with which the organization contracts that have significant minority populations
- Labor unions
- Agencies that serve the population group of interest
- Researchers involved in minority community-based research

**Opportunities to involve the minority community**

- Advisory panels
- Community forums to review and solicit feedback on culturally and linguistically appropriate services initiatives
- Focus groups
- Participation on working committees

**Evidence of governing body approval**

- Minutes reflecting review of goals by governing body
- Approved budget reflecting resource allocation to meet the goals
- Minutes or signed plan reflecting governing body sign-off of goals and resources

**Element B: Annual Evaluation**

There is an annual written evaluation of the culturally and linguistically appropriate services plan that includes the following.

1. **A description of completed and ongoing activities for culturally and linguistically appropriate services**
2. **Trending of measures to assess performance**
3. **Analysis of results of initiatives, including barrier analysis**
4. **Review and interpretation of the results by community representatives**
5. **Evaluation of the overall effectiveness of the program**

<b>Scoring</b>	<b>100%</b>	<b>80%</b>	<b>50%</b>	<b>20%</b>	<b>0%</b>
	Annual evaluation includes all 5 factors	Annual evaluation includes 4 factors	Annual evaluation includes 3 factors	Annual evaluation includes 2 factors	Annual evaluation includes 0-1 factors

**Data source** Reports, materials

**Scope of review**

**Explanation** The annual evaluation may be independent, or it may be integrated within the QI program annual evaluation.

**Completed and ongoing activities**

The organization must annually evaluate its performance on planned culturally and linguistically appropriate services activities described within its program description and work plan, including all delegated functions. Evaluation must include a description of completed and ongoing culturally and linguistically appropriate services activities for the previous year.

**Trending of measures**

The organization should present the results of culturally and linguistically appropriate services initiatives in measurable terms. To facilitate comparative analysis, evaluation must include trended data using charts, graphs or tables for displaying this information. Trended data show performance over time.

**Analysis of results, including barrier analysis**

The organization must analyze its results to determine whether performance is improving, declining or remaining stable and how performance is related to goals or performance thresholds identified in the plan. When performance falls short of goals, the organization must conduct a root cause analysis or barrier analysis to identify why goals were not met. Analysis must include organization staff who have direct experience with the processes that present barriers to improvement.

**Review and interpretation of results by community representatives**

The organization must include community representatives in the evaluation. At a minimum, the organization must present the analysis to community representatives for review and comment. The organization may choose a more integrated approach and include community representatives on the evaluation team. The organization should consult community representatives on the barrier analysis, as they may have unique perspectives on the root cause of barriers and possible solutions.

**Evaluation of overall effectiveness**

After giving careful consideration to its performance in all aspects of the culturally and linguistically appropriate services program, the organization determines and describes the program's overall effectiveness. The organization considers the adequacy of resources, program structure, participation of practitioners and community representatives and leadership involvement in the program, and determines whether to restructure or change it for the subsequent year, based on its findings.

**Examples****Annual written evaluation contents**

- The title of each culturally and linguistically appropriate services initiative described in the work plan
- A description of the initiative
- The major accomplishments
- Appropriate measures trended over time, including:
  - Member experience data
  - Practitioner experience data
  - Staff feedback
  - Service performance (e.g., telephone hold times; interpreter wait times)
- Issues and barriers that make objectives more difficult to achieve
- Recommended interventions to overcome barriers and issues
- Assessment of the extent to which yearly planned activities were completed and yearly objectives were met

**Community representatives:**

- Members/patients from racial, ethnic or linguistic minority groups
- Community advocates
- Employers with which the organization contracts that have significant minority populations
- Labor unions
- Agencies that serve the population group of interest
- Minority behavioral researchers

## AQI 2: Reducing Health Care Disparities

The organization uses member race/ethnicity and language data to assess the existence of disparities and to focus quality improvement efforts toward improving the provision of culturally and linguistically appropriate services and decreasing health care disparities.

### Intent

The organization uses data about its population to improve service and reduce health care disparities.

### Element A: Use of Data to Assess Health Care Disparities

The organization uses race/ethnicity and language data and the following methods to determine if health care disparities exist.

1. Stratifying one or more HEDIS or other clinical performance measures by race/ethnicity
2. Stratifying one or more HEDIS or other clinical performance measures by language
3. Stratifying one or more CAHPS or other member experience measures by race/ethnicity or language
4. Comparing performance data for racial, ethnic or linguistic subgroups against a pre-defined reference group

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization does not assess the presence of disparities

**Data source** Reports

**Scope of review**

**Explanation** The organization must stratify its data by race/ethnicity and language to assess health care disparities. While oversampling may be required in order to obtain statistically valid results, the organization is not required to conduct tests of statistical significance.

#### Quantitative analysis

Analysis of findings must include a first-level, quantitative data analysis that incorporates aggregate results and compares the results for each subsample against the best-performing sub-sample or a pre-defined benchmark or reference group. For HEDIS® and CAHPS data, the comparison could be against the overall or regional benchmarks and thresholds published by NCQA. If an organization has multiple locations within a state, it may analyze statewide data, but aggregate data may not provide sufficient information about actions the organization should take at each location.

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**Qualitative analysis**

Because stratification of quantitative data may yield sample sizes too small to make valid statistical inferences, the organization may conduct qualitative analysis—such as through interviews or focus groups or evaluation of complaints and grievances—to supplement its understanding of the data. Qualitative analysis alone is insufficient to satisfy this element.

**Stratifying clinical performance measures by race/ethnicity**

The organization may stratify one or more HEDIS or other clinical performance measures by using member-level data; for example, for measures that employ the hybrid method, or using information systems that can identify individual members captured in the numerator and denominator of the measure. The organization must stratify the measure both by race (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Multiracial) and ethnicity (Hispanic/Latino or not Hispanic/Latino).

The organization may use either direct or indirect data for stratification. It need not evaluate for every racial or ethnic subgroup, but it should focus on those most relevant to its member demographics and feasible, given the number of members in those groups. Some subgroups may stand alone, such as “White” and “African American”; some may need to be grouped as “Other.”

Some organizations may stratify to more granular subgroups than required by the OMB, such as Cantonese, Chinese and Vietnamese rather than “Asian.” NCQA is not prescriptive about which performance measures an organization stratifies, but it suggests that the organization focus on disparity-sensitive measures specified by the NQF and, in particular, measures of care processes or outcomes relevant to the organization’s population.

**Stratifying clinical performance measures by language**

The organization may stratify one or more HEDIS or other clinical performance measures using member-level data (e.g., for measures that employ the Hybrid Method) or by using information systems that can identify individual members captured in the numerator and denominator of the measure. The organization must stratify the measure by member language, using the languages most relevant to the membership. If the demographics do not allow further stratification, the organization may only be able to stratify by “English/Other.”

**Stratifying member experience measures by race/ethnicity or language**

The organization may stratify one or more CAHPS or other member Experience of Care measures using member-level data, including data collected by the CAHPS survey. The organization should focus on population subgroups that are most relevant to member demographics.

**Comparing performance data against a pre-defined reference group**

When determining whether disparities exist at a single point in time, it may be possible to compare all subgroups; for example, in a box chart that shows each subgroup’s performance and the confidence interval around the data point. When evaluating trended data over time, the organization may prefer to compare all subgroups against the most advantaged group. The most advantaged group, or the one with the best performance, would be the reference group.

**Exception**

This element is NA if the organization can demonstrate that it has fewer than 30 members of any minority racial, ethnic or linguistic group that might be included in any measures to conduct a comparison.

**Examples****Stratifying performance data**

- Analysis of HbA1c screening rates for African Americans, Whites and Other
- Analysis of how well doctors communicate by English/Spanish/Other
- Analysis of rating of personal doctor by English, Spanish, Cantonese, Vietnamese
- Analysis of experience with choice of practitioner (not a CAHPS item) by White Latino/Hispanic, White Not Latino/Hispanic, African American Latino/Hispanic, African American Not Latino/Hispanic

**Predefined reference group**

- White
- Speaks English
- The highest-performing subgroup

**NQF disparities—sensitive measures**

The NQF has published a national set of disparity-sensitive performance measures in eight priority areas (asthma; diabetes; heart disease; hypertension; medication management; mental health and substance use; prenatal care; and prevention, immunization and screening) and one additional measure in the area of patient experience with care [*National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities: A Consensus Report*. National Quality Forum. 2008].

**Priority area: Asthma**

- Use of appropriate medications for people with asthma
- Pharmacologic therapy

**Priority area: Diabetes**

- HbA1c test for pediatric patients
- Percentage of patients with at least one LDL-C test
- Percentage of patients who received a dilated eye exam or seven standard-field stereoscopic photos, with interpretation by an ophthalmologist or optometrist; or imaging validated to match diagnosis from these photos during the reporting year, or during the prior year, if patient is at low risk for retinopathy
- Percentage of eligible patients receiving at least one foot exam
- Percentage of patients with one or more A1c tests
- Percentage of patients with most recent A1c level >9.0% (poor control)
- Percentage of patients with most recent blood pressure <140/80 mm Hg
- Percentage of patients with at least one test for microalbumin during the measurement year, or who had evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microalbuminuria or albuminuria)

**Priority area: Heart disease**

- *Coronary artery disease (CAD)*: angiotensin-converting enzyme inhibitor (ACE inhibitor)/angiotensin receptor blocker (ARB) therapy
- *CAD*: Beta-blocker therapy—prior myocardial infarction (MI)
- *CAD*: Beta-blocker treatment after a heart attack
- *Ischemic vascular disease (IVD)*: Complete IVD: patients with a full lipid profile completed during the 12-month measurement period with date of lipid profile and LDL control <100 each component of the profile documented; LDL-C<100
- *Heart failure*: Left ventricular function (LVF) assessment
- *Heart failure*: ACE inhibitor/ARB therapy

**Priority area: Hypertension**

- Controlling high blood pressure

**Priority area: Medication management**

- Drugs to be avoided in the elderly
  - Patients who receive at least one drug to be avoided
  - Patients who receive at least two different drugs to be avoided

**Priority area: Mental health and substance use**

- Antidepressant medication management
- Initiation and engagement of alcohol and other drug dependence treatment

**Priority area: Prenatal care**

- Prenatal screening for HIV
- Prenatal anti-D immune globulin
- Prenatal blood group and type
- Prenatal D antibody testing

**Priority area: Immunization**

- Childhood immunization status
- Flu shots for adults ages 50–64
- Flu shot for older adults
- Pneumonia vaccination status for older adults

**Priority area: Screening**

- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening

**Priority area: Prevention**

- Smoking cessation—medical assistance
  - Advising smokers to quit
  - Discussing smoking cessation medications
  - Discussing smoking cessation strategies
- Prevention measure pair
  - Tobacco use assessment
  - Tobacco cessation intervention
- Prevention measure pair
  - Tobacco use prevention or prevention of exposure for infants, children and adolescents
  - Tobacco use cessation for adolescents and caretakers of infants and children.
- Patient experience with care Ambulatory Consumer Assessment of Healthcare Providers and Systems (ACAHPS®)

**Element B: Use of Data to Reduce Health Care Disparities**

Based on the results of measurement of health care disparities, the organization annually:

1. Identifies opportunities to reduce health care disparities
2. Implements at least one intervention to address a disparity
3. Evaluates the effectiveness of the intervention.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

**Data source** Reports

**Scope of review**

**Explanation** The organization must perform QI interventions annually to reduce health care disparities.

#### **Identifying and prioritizing opportunities for improvement**

The organization must identify as many opportunities for improvement as possible, prioritize them based on its analysis and their significance for concerns to members and indicate how it chose them. NCQA uses the analysis to evaluate whether chosen priorities reflect significant issues. For each opportunity or barrier, the organization must describe its reasons for taking (or not taking) action. The organization may engage members of the target community in this effort, through community advisory boards—including community representatives or leaders—on an internal project team; bringing data to a community meeting and soliciting input on priorities; or other means that provide a meaningful avenue for members of the affected community or subpopulation to contribute to the selection and design of the intervention.

#### **Implementing interventions**

Research indicates that the most successful approaches to reducing health care disparities are multifaceted [Beal, A.C. *Policies To Reduce Racial And Ethnic Disparities In Child Health And Health Care. Health Affairs*, 2004, 23(5): 171-179; Cooper, L.A., M.N. Hill, N.R. Powe. *Designing and Evaluating Interventions to Eliminate Racial and Ethnic Disparities in Health Care. JGIM*. 2002 Vol 17(6):477-486.]. NCQA recognizes that implementing interventions can be a complex process that occurs over time.

NCQA evaluates whether the organization has fully implemented at least one intervention to address a prioritized opportunity. The organization must indicate the logic behind its chosen intervention. Interventions and QI activities may take place at the health-plan level or, if the organization plays a significant supporting or sponsoring role, in the network; including, for example, sharing data on race/ethnicity and language (with members' permission) with network practitioners to facilitate targeted outreach or more proactive arrangements for language services.

#### **Evaluating the effectiveness of the intervention**

While the goal of interventions is ultimately to reduce health care disparities, many interventions focus on one aspect of the problem. Evaluation may focus on the elimination or reduction of the disparity of interest or it may focus on an intermediate measure derived from the logic model for the intervention.

**Examples**      **Identifying and prioritizing opportunities for improvement**

XYZ Organization's analysis indicated that significant health care disparities exist in several clinical areas: mammography screening, HbA1c control and blood pressure control. In all three cases, African Americans fare worse than Whites. Because of the prevalence of hypertension and diabetes among African Americans, and because of the serious consequences of both high blood pressure and uncontrolled diabetes, the organization prioritized these two areas of disparity over mammography screening. To focus on a manageable effort and because the diabetes disease management program was only recently reorganized, the organization selected hypertension as the first area for which to develop an intervention.

**Developing an intervention**

XYZ Organization recognized that in order to develop an effective intervention, it needed better understanding of the reasons for disparate results. QI staff identified practitioners who provided care to a large number of African American members with hypertension and practitioners who provided care to White members with hypertension. Chart reviews and interviews were conducted to understand the differences in care provided and outcomes achieved.

Analysis revealed that blood pressure screening was documented somewhat less frequently for African American patients, but that even when screening rates were comparable, African Americans patients' blood pressure was above normal more often. Interviews with providers suggested several contributing factors: African American patients found it more difficult to visit the doctor's office as frequently as required to check blood pressure and adjust medicines, and practitioners felt that African American patients did not adhere to medication regimens as well as other patients.

XYZ Organization determined that a patient-focused intervention was required. It worked with its disease management program to develop culturally competent outreach materials, and specifically addressed the risks to African Americans in hope of enrolling more in the disease management program. The program also recruited an African American nurse to conduct outreach calls, and provided home blood pressure monitoring kits to patients enrolled in the disease management program. The organization decided to continue to study the reasons for poor medication adherence.

**Evaluating effectiveness**

While XYZ Organization hoped its interventions would result in improvement in blood pressure control for its African American members, it was realistic in recognizing that improvement would take time. In the interim, the organization evaluated intermediate outcomes associated with its interventions. The organization measured the rate of enrollment by African American members with hypertension in the disease management program before and after its intervention, and conducted chart reviews for a sample of patients and practitioners to determine whether blood pressure was being recorded more frequently in patients' charts.