



Measure Information

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

Brief Measure Information
<p>NQF #: 1905</p> <p>Corresponding Measures:</p> <p>De.2. Measure Title: Leadership commitment measure derived from the leadership commitment domain of the C-CAT</p> <p>Co.1.1. Measure Steward: University of Colorado Center for Bioethics & Humanities</p> <p>De.3. Brief Description of Measure: 0-100 measure of leadership commitment to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit</p> <p>1b.1. Developer Rationale: Understanding and improving communication may be a key to addressing disparities, which is an important national health policy goal.</p>
<p>S.4. Numerator Statement: Leadership commitment component of patient-centered communication: an organization should routinely examine its commitment, capacity and efforts to meet the communication need of the population it serves, including leadership involvement; mission, goals and strategies; policies and programs; budget allocations; and workforce values. Measure is scored based on 7 items from C-CAT patient survey and 16 items from C-CAT staff survey. Minimum of 100 patient responses and 50 staff responses</p> <p>S.6. Denominator Statement: There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses.</p> <p>S.8. Denominator Exclusions: Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.</p>
<p>De.1. Measure Type: Outcome</p> <p>S.17. Data Source: Instrument-Based Data</p> <p>S.20. Level of Analysis: Facility</p>
<p>IF Endorsement Maintenance – Original Endorsement Date: Aug 09, 2012 Most Recent Endorsement Date: Aug 09, 2012</p>
<p>IF this measure is included in a composite, NQF Composite#/title:</p> <p>IF this measure is paired/grouped, NQF#/title:</p> <p>De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A</p>

1. Evidence, Performance Gap, Priority – Importance to Measure and Report
<p>Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.</p>
<p>1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form 1905_Evidence_MSF5.0_Data.doc</p> <p>1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?</p>

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

1b. Performance Gap

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

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

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

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Understanding and improving communication may be a key to addressing disparities, which is an important national health policy goal.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (*This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.*) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Performance on the leadership commitment measure (domain) of the CCAT varies across sites. During field-testing of the instrument, the low and high site scores in the domain of leadership commitment were 67.2 and 76.6 (delta of 9.4).

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

Wynia MK, Johnson M, McCoy TP, Griffin LP, Osborn CY. 2010. Validation of an Organizational Communication Climate Assessment Toolkit. Am J Med Qual. XX(X).

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Research has shown that LEP patients and patients from minority racial/ethnic groups experience communication problems more frequently than patients who speak English and those from traditionally advantaged groups. Regarding LEP patients, Flores (2005) has shown that provision of interpreters for LEP patients positively affects preventive screening rates, while those who either get no interpreter or an ad hoc interpreter have more medical tests, higher costs, and higher rates of hospitalization. Regarding patients of minority race/ethnicity, Hausmann et al (2011) have found that perceived racism is higher among African American patients than White patients, and that perceived racism negatively affects patient ratings of ease of communication (OR 0.22, 95% CI 0.07-0.67).

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

1. Hausmann L, Hannon MJ, Kresevic DM, Hanusa BH, Kwok CK, Ibrahim SA. 2011. Impact of Perceived Discrimination in Healthcare on Patient-Provider Communication. Med Care. 49;7:626-633.

2. Cene CW, Roter D, Carson KA, Miller ER III, Cooper LA. The effect of patient race and blood pressure control on patient-physician communication. J Gen Intern Med. 2009;24:1057-1064.

3. Weech-Maldonado R, Fongwa MN, Gutierrez P, Hays RD.

Language and regional differences in evaluations of Medicare managed care by Hispanics. Health Serv Res. 2008;43:552-568.

4. Flores G. 2005. The Impact of Medical Interpreter Services on the Quality of Health Care: A Systemic Review. Med Care Res Rev. 62;255. Language and regional differences in evaluations of Medicare managed care by Hispanics. Health Serv Res. 2008;43:552-568.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

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

Care Coordination, Disparities Sensitive, Person-and Family-Centered Care, Safety

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

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

www.ucdenver.edu/c-cat

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

This is not an eMeasure Attachment:

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

Attachment Attachment: [UPDATED_2.2016_CCAT_Crosswalk_with_content_and_scoring.xls](#)

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Leadership commitment component of patient-centered communication: an organization should routinely examine its commitment, capacity and efforts to meet the communication need of the population it serves, including leadership involvement; mission, goals and strategies; policies and programs; budget allocations; and workforce values. Measure is scored based on 7 items from C-CAT patient survey and 16 items from C-CAT staff survey. Minimum of 100 patient responses and 50 staff responses

S.5. Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The measure result is obtained by calculating a 0-100 score for both the patient and staff component of the measure. Item language is adjusted based on whether site is a hospital or clinic.

Patient survey items:

- p6. Was it easy to ask questions at the hospital (clinic)?
- p10. Was information in the waiting areas helpful?
- p28. Was it easy to reach someone on the phone if you had a question?
- p31. Do you feel welcome at the hospital (clinic)?
- p32. Are you happy with the care you get at the hospital (clinic)?
- p33. Does the hospital (clinic) communicate well with patients?
- p36. Would you bring a family member to this hospital (clinic)?

Staff survey items:

- s1. Senior leaders have taken steps to create a more welcoming environment for patients.
- s2. Senior leaders have taken steps to promote a more patient-centered environment.
- s3. Senior leaders have made effective communication with diverse populations a priority.
- s5. Senior leaders have rewarded staff and departments that work to improve communication.
- s6. My direct supervisors have intervened if staff were not respectful towards patients.
- s9. My direct supervisors have asked for my suggestions on how to improve communication within the hospital (clinic).
- s10. My direct supervisors have used my feedback to improve communication within the hospital (clinic).
- s13. Hospital (clinic) staff members have shown that they care about communicating effectively with diverse populations.
- s14. Hospital (clinic) staff members have spoken openly with supervisors about any miscommunications.
- s15. Hospital (clinic) staff members have known whom to call if they have a problem or suggestion.
- s16. Hospital (clinic) staff members have communicated well with patients over the phone.
- s17. Hospital (clinic) staff members have communicated with each other respectfully.
- s18. Hospital (clinic) staff members have communicated with each other effectively to ensure high quality care.
- s19. Hospital (clinic) staff members have needed more time to communicate well with patients.
- s52. Have you ever received specific and adequate training on communication policies at the hospital (clinic)?
- s53. Have you ever received specific and adequate training on the

impact of miscommunication on patient safety?

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Staff respondents should include all staff categories, including both clinical and non-clinical staff as well as those in roles such as building/environmental services, food services, etc. A minimum of 50 staff responses in a variety of staff categories is required to calculate the measure score. Staff surveys are made available in English and Spanish by default, with additional language available upon request. Patient respondents include all patients, with a pediatric version made available for families of minor patients. During field testing, patient surveys were available in 5 languages: English, Spanish, Chinese, Polish and Vietnamese. Currently, English and Spanish language surveys are made available by default with additional languages available upon request (languages determined by organization using the C-CAT).

During field testing of the instruments, surveys were available on paper or online and during phase 1 patient surveys were also available via automated voice response systems. After very few patients replied using the voice automated system, the system was retired from use.

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Staff respondents who do not have direct contact with patients are excluded from questions that specifically address patient contact.

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

Based on response to the first item on the staff survey ("Does your job involve direct contact with patients? yes/no"), staff respondents who do not have direct contact with patients are excluded from items that relate to direct contact with patients.

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

N/A

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Ratio

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

The measure score is an average of the patient and staff components.

Calculation of patient component of measure score: each response of "never" counts as 0; each response of "sometimes" counts as 0.5; each response of "always" counts as 1.0; responses of "not sure" are excluded. A composite score for each item is calculated by summing the total response scores and dividing by the number of valid responses ("not sure" excluded); this operation is repeated for each item; an average of all patient items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the patient component of "leadership commitment."

For the staff component: each response of "strongly disagree" counts as 0; each response of "disagree" counts as 0.33; each response of "agree" counts as 0.67; each response of "strongly agree" counts as 1.0; responses of "n/a" or "not sure" are excluded. A composite score for each item is calculated by summing the total response score and dividing by the number of valid responses ("n/a" and "not sure" excluded); this operation is repeated for each item; an average of all staff items is calculated; this average is multiplied by 100, resulting in a 0-100 score for the staff component of the domain of "leadership commitment."

The average of the staff and patient components is obtained, resulting in the measure score for the domain of leadership commitment to patient-centered community.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

Those using the measure are encouraged to get as close to a universal sample as possible over a short period of time.

Required number of responses and response rate: To complete analysis, a minimum of 100 responses to the patient survey and 50 responses to the staff survey are required. To compare subgroups a minimum of 50 surveys from each group to be compared is required. If subgroup analysis (e.g. Spanish speaking patients, patients over age 65, etc.) is to be performed, over-sampling of the targeted group is likely necessary to achieve enough of these surveys to complete comparative analyses. Although response rates vary, we generally anticipate a 20% response rate to the patient survey, which means that to achieve 100 responses about 500 surveys will need to be distributed.

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

A trained consultant works with a site liaison to determine the number of paper and electronic surveys to be distributed to achieve the minimum response required. Considerations include timing of survey deployment, language translations and how paper surveys will be returned.

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Instrument-Based Data

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Communication Climate Assessment Toolkit (C-CAT) survey instruments (staff and patient). Available

at:<http://www.ucdenver.edu/academics/colleges/medicalschoo/centers/BioethicsHumanities/academicactivities/Pages/C-CAT-Surveys.aspx>

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available at measure-specific web page URL identified in S.1

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Inpatient/Hospital, Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2. Validity – See attached Measure Testing Submission Form

[1905_MeasureTesting_MSFS.0_Data.doc](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

Other

If other: [Patient and staff surveys collect data from eligible respondents](#)

3b. Electronic Sources

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

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

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

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

[The majority of staff data is collected through email-based surveys, with paper surveys made available for those staff members who do not have email access.](#)

[Patient surveys are distributed on paper, as many patients who are most likely to be affected by miscommunication \(e.g., those with lower literacy\) may not be comfortable with email-based surveys. In order to address this concern, an iPad app has been developed](#)

which includes an audio functionality that is useful to low literacy and low vision patients.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

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

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

AMA has developed a preferred method for using the measures, in which sites wishing to use the measure work directly with a trained and licensed consultant. The consultant is able to provide guidance on preparation, data collection, and interpretation of results.

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

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

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

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4a2.2.2. Summarize the feedback obtained from those being measured.

4a2.2.3. Summarize the feedback obtained from other users

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Improvement

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

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

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

4b2. Unintended Consequences

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

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

As data is collected by survey, respondents' answers could potentially be inaccurate. However, psychometric testing and validation of the instruments found a high degree of reliability.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

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

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

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications harmonized to the extent possible?

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

5b. Competing Measures

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

OR

Multiple measures are justified.

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

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

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific

submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Available at [measure-specific web page URL identified in S.1](#) **Attachment:**

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [University of Colorado Center for Bioethics & Humanities](#)

Co.2 Point of Contact: [Matthew, Wynia, matthew.wynia@ucdenver.edu, 303-724-3991-](#)

Co.3 Measure Developer if different from Measure Steward: [University of Colorado Center for Bioethics & Humanities](#)

Co.4 Point of Contact: [Matthew, Wynia, matthew.wynia@ucdenver.edu, 303-724-3991-](#)

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

[An expert advisory panel was convened to review literature on potential domains/measures, suggest measurement framework, and suggest measurable expectations within content area. Members of the expert advisory panel were:](#)

[Dennis Andrulis, PhD, MPH](#)
[Drexel University School of Public Health](#)

[David W. Baker, MD, MPH, FACP](#)
[Northwestern Memorial Hospital](#)

[David Fleming, MD](#)
[Center for Health Ethics, University of Missouri - Columbia](#)

[Elizabeth Heitman, PhD](#)
[Center for Medical Ethics, Vanderbilt University](#)

[Sharon King-Donohue, JD](#)
[National Committee for Quality Assurance](#)

[Edward L. Martinez, MS](#)
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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2010

Ad.3 Month and Year of most recent revision: 04, 2011

Ad.4 What is your frequency for review/update of this measure? Annual

Ad.5 When is the next scheduled review/update for this measure? 03, 2012

Ad.6 Copyright statement: ©American Medical Association, 2012.

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Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: This measure is used in conjunction with additional instruments, namely a survey of executive leadership and a workbook on organizational policy; these instruments, as well as the other C-CAT instruments, are available for viewing at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page?>. The information collected through the executive survey and policy workbook provide important contextual information, but are not components in the calculation of the measure score. Further information is available at ethicalforce.org, or through the contact information for the measure developer and steward.