Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL QUALITY MEASURES CLEARINGHOUSE

General

Title

Communication climate: mean score for the "Performance Evaluation" domain on the Patient (or Pediatric) Survey and Staff Survey.

Source(s)

Communication climate assessment toolkit: adult patient survey. Aurora (CO): University of Colorado-Center for Bioethics & Humanities; 2015. 5 p.

Communication climate assessment toolkit: pediatric patient (parents/guardians complete) survey. Aurora (CO): University of Colorado-Center for Bioethics & Humanities; 2015. 4 p.

Communication climate assessment toolkit: staff survey. Aurora (CO): University of Colorado-Center for Bioethics & Humanities; 2015. 4 p.

Measure Domain

Primary Measure Domain

Clinical Quality Measures: Structure

Secondary Measure Domain

Clinical Quality Measure: Patient Experience

Brief Abstract

Description

This measure is used to assess the mean score for the "Performance Evaluation" domain on the Communication Climate Assessment Toolkit (C-CAT) Patient (or Pediatric) Survey and Staff Survey.

This domain comprises 1 item on the Patient (or Pediatric) Survey and 7 items on the Staff Survey:

Patient (or Pediatric) Survey

Did you know whom to call if you wanted to complain?

Staff Survey

Senior leaders have rewarded staff and departments that work to improve communication.
My direct supervisors have intervened if staff were not respectful towards patients.
My direct supervisors have monitored whether I communicate effectively with patients.
My direct supervisors have asked for my suggestions on how to improve communication within the hospital (clinic).
My direct supervisors have used my feedback to improve communication within the hospital (clinic).
Hospital (clinic) staff members have spoken openly with supervisors about any miscommunications.
Hospital (clinic) staff members have known whom to call if they have a problem or suggestion.

Note: To calculate domain scores, all relevant survey item responses were first standardized to a 0-to-1 scale, with 1 being the most desired response. For each domain, the mean of all included items was calculated for each survey to obtain patient and staff survey domain means (this accounts for varying numbers of items in each domain as well as the varying numbers of surveys collected at different sites). Finally, the means of the patient survey and the staff survey domain means were calculated (so that staff and patient scores carry equal weight in the overall domain score) and multiplied by 100. The domain scores are thus reported on standardized scales of 0 to 100 for each organization, with 100 being the best possible score. Refer to the *C-CAT Sampling and Analysis Guide* in the "Companion Documents" field for additional information.

This measure is one of nine composite measures derived from the C-CAT.

Rationale

Effective communication is the foundation for quality health care (Kaplan, Greenfield, & Ware, 1989; Flach et al., 2004; Markova & Broome, 2007; Institute of Medicine Committee on Communication for Behavior Change in the 21st Century, 2002; Ashton et al., 2003; Gordon, Baker, & Levinson, 1995; Seidel, 2004; Wanzer, Booth-Butterfield, & Gruber, 2004; Safran et al., 2001; Zolnierek & Dimatteo, 2009; Divi et al., 2007; The Joint Commission, 2007; Scalise, 2006). Communication between health care practitioners, patients, and other members of care teams affects patient satisfaction (Gordon, Baker, & Levinson, 1995; Wanzer, Booth-Butterfield, & Gruber, 2004; Safran et al., 2001), adherence to treatment recommendations (Seidel, 2004; Safran et al., 2001; Zolnierek & Dimatteo, 2009), and patient safety (Divi et al., 2007; The Joint Commission, 2007; Scalise, 2006). According to the Joint Commission, miscommunication is the leading cause of sentinel events (serious medical errors) (The Joint Commission, 2007). In addition, health and health care disparities are created when miscommunication disproportionately affects certain patient populations (Institute of Medicine Committee on Communication for Behavior Change in the 21st Century, 2002; Ashton et al., 2003; Gregg, 2004; Cene et al., 2009; Weech-Maldonado et al., 2008). As a result, understanding and improving communication may be a key to addressing disparities (Institute of Medicine Committee on Communication for Behavior Change in the 21st Century, 2002), which is an important national health policy goal (U.S. Department of Health and Human Services, 2009).

Patient-centered communication is well recognized as a key to quality care, and an organization's climate and infrastructure can affect communication in a number of important ways. A set of assessment tools was developed to measure a hospital or clinic's organizational climate specifically in regard to patient-centered communication. The tools provide a 360° evaluation of organizational communication climate and include patient and staff surveys that can be used to derive standardized domain scores in each of 9 key areas of organizational communication climate.

An organization should regularly monitor its performance with regard to each content area using structure, process and outcome measures, and make appropriate adjustments on the basis of these evaluations.

Evidence for Rationale

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climate assessment toolkit. Am J Med Qual. 2010 Nov-Dec;25(6):436-43. [39 references] PubMed

Zolnierek KB, Dimatteo MR. Physician communication and patient adherence to treatment: a meta-analysis. Med Care. 2009 Aug;47(8):826-34. PubMed

Primary Health Components

Patient experience; staff experience; communication; performance evaluation

Denominator Description

Total number of items in the "Performance Evaluation" domain on the Patient (or Pediatric) Survey and Staff Survey (see the related "Denominator Inclusions/Exclusions" field)

Numerator Description

The sum of scores for each item in the "Performance Evaluation" domain (see the related "Numerator Inclusions/Exclusions" field)

Evidence Supporting the Measure

Type of Evidence Supporting the Criterion of Quality for the Measure

A formal consensus procedure, involving experts in relevant clinical, methodological, public health and organizational sciences

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Additional Information Supporting Need for the Measure

- Health literacy refers to a person's ability to understand and act on health information (Institute of Medicine [IOM], 2004). A growing body of evidence demonstrates that compared to individuals with adequate health literacy skills, those with limited health literacy are more likely to misunderstand health information (Friedman, Hoffman-Goetz, & Arocha, 2006); face difficulty following medical instructions (Davis et al., 2006); inappropriately or infrequently use health care services (Gazmararian et al., 1999; Sudore et al., 2006); have worse physical and mental health (Wolf, Gazmararian, & Baker, 2005); experience higher rates of hospitalization (Baker et al., 2002); and have a shorter life expectancy (Baker et al., 2007). Efforts to overcome limited health literacy have included developing plain language, patient-friendly education materials and navigation aids (Stableford & Mettger, 2007); educating healthcare professionals about health literacy issues (Riley, Cloonan, & Rogan, 2008); redesigning patient informed consent forms (Lorenzen, Melby, & Earles, 2008); and using established communication methods such as the "teach back" techniques when communicating with patients (Villaire & Mayer, 2007). While experts agree that implementing a range of system-wide strategies may be the most effective means of overcoming limited health literacy (Murphy-Knoll, 2007; O'Leary, Davis, & Cordell, 2007), system-wide change to address limited health literacy has been difficult to stimulate and slow to develop in most health care organizations (Stableford & Mettger, 2007).
- Recent evidence suggests that even when providers know about health literacy and the need for enhanced communication techniques, they underutilize these strategies (Turner et al., 2009). Many

effective health communication strategies have been studied by physicians, nurses, and pharmacists, but remain unincorporated into routine clinical practice (Schwartzberg et al., 2007).

- Obtaining informed consent is difficult when there are communication gaps between the clinician and the patient. For example, more than 90 million people in the United States (43% of adults) have literacy levels below what they need to understand most health information, including informed consent discussions (Marcus, 2006; National Center for Education Statistics [NCES], 2006; IOM, 2004). Lack of adequate skills to read or understand health care information is a particularly serious problem for the elderly, recent immigrants, and patients with limited educational attainment (Weiss, 2005). In addition, 22 million Americans have limited English proficiency, which poses a significant hurdle to effective health care communication (Flores, 2006).
- Research has shown that limited English proficiency (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, Hausman 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 (odds ratio [OR] 0.22, 95% confidence interval [CI] 0.07 to 0.67).

Evidence for Additional Information Supporting Need for the Measure

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Extent of Measure Testing

Effective communication is critical to providing quality health care and can be affected by a number of modifiable organizational factors. Wynia et al. (2010) performed a prospective multisite validation study of an organizational communication climate assessment tool in 13 geographically and ethnically diverse health care organizations. Communication climate was measured across 9 discrete domains. Patient and staff surveys with matched items in each domain were developed using a national consensus process, which then underwent psychometric field testing and assessment of domain coherence. The authors found meaningful within-site and between-site performance score variability in all domains. In multivariable models, most communication domains were significant predictors of patient-reported quality of care and trust. The authors conclude that these assessment tools provide a valid empirical assessment of organizational communication climate in 9 domains. Assessment results may be useful to track organizational performance, to benchmark, and to inform tailored quality improvement interventions.

Evidence for Extent of Measure Testing

Wynia MK, Johnson M, McCoy TP, Griffin LP, Osborn CY. Validation of an organizational communication climate assessment toolkit. Am J Med Qual. 2010 Nov-Dec;25(6):436-43. [39 references] PubMed

State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Ambulatory/Office-based Care

Hospital Inpatient

Hospital Outpatient

Professionals Involved in Delivery of Health Services

not defined yet

Least Aggregated Level of Services Delivery Addressed

Clinical Practice or Public Health Sites

Statement of Acceptable Minimum Sample Size

Specified

Target Population Age

Unspecified

Target Population Gender

Either male or female

National Strategy for Quality Improvement in Health Care

National Quality Strategy Aim

Better Care

National Quality Strategy Priority

Health and Well-being of Communities
Person- and Family-centered Care
Prevention and Treatment of Leading Causes of Mortality

Institute of Medicine (IOM) National Health Care Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Data Collection for the Measure

Case Finding Period

A brief, discrete data collection period is preferred. A data collection period of between 1 and 4 weeks is

usually sufficient to collect needed data.

Denominator Sampling Frame

Professionals/Staff

Denominator (Index) Event or Characteristic

Does not apply to this measure

Denominator Time Window

not defined yet

Denominator Inclusions/Exclusions

Inclusions
Total number of items in the "Performance Evaluation" domain on the Patient (or Pediatric) Survey and Staff Survey

Note: Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses.

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

Exclusions/Exceptions

not defined yet

Numerator Inclusions/Exclusions

Inclusions
The sum of scores for each item in the "Performance Evaluation" domain

Note: To calculate domain scores, all relevant survey item responses were first standardized to a 0-to-1 scale, with 1 being the most desired response. For each domain, the mean of all included items was calculated for each survey to obtain patient and staff survey domain means. Finally, the means of the patient survey and the staff survey domain means were calculated and multiplied by 100. The domain scores are reported on standardized scales of 0 to 100, with 100 being the best possible score. Refer to the *C-CAT Sampling and Analysis Guide* in the "Companion Documents" field for additional information.

Exclusions
Responses of "Not Sure" and "N/A" are excluded.

Numerator Search Strategy

Fixed time period or point in time

Data Source

Health professional survey

Patient/Individual survey

Type of Health State

Does not apply to this measure

Instruments Used and/or Associated with the Measure

Communication Climate Assessment Toolkit (C-CAT):

- Adult Patient Survey
- Pediatric Patient Survey
- Staff Survey

Computation of the Measure

Measure Specifies Disaggregation

Does not apply to this measure

Scoring

Composite/Scale

Mean/Median

Interpretation of Score

Desired value is a higher score

Allowance for Patient or Population Factors

not defined yet

Standard of Comparison

not defined yet

Identifying Information

Original Title

Performance evaluation.

Measure Collection Name

Communication Climate Assessment Toolkit (C-CAT)

Submitter

University of Colorado Center for Bioethics and Humanities - Academic Affiliated Research Institute

Developer

University of Colorado Center for Bioethics and Humanities - Academic Affiliated Research Institute

Funding Source(s)

- American Medical Association (AMA)
- California Endowment
- The Commonwealth Fund
- Connecticut Health Foundation

Composition of the Group that Developed the Measure

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Financial Disclosures/Other Potential Conflicts of Interest

Unspecified

Endorser

National Quality Forum - None

NQF Number

not defined yet

Date of Endorsement

2012 Aug 9

Adaptation

This measure was not adapted from another source.

Date of Most Current Version in NQMC

2015 Jan

Measure Maintenance

Annual

Date of Next Anticipated Revision

Unspecified

Measure Status

This is the current release of the measure.

This measure updates previous versions:

> Communication climate assessment toolkit: adult patient survey. Chicago (IL): American Medical Association (AMA); 2012 Jan. 4 p.
> Communication climate assessment toolkit: pediatric patient (parents/guardians complete) survey. Chicago (IL): American Medical Association (AMA); 2012 Jan. 4 p.
> Communication climate assessment toolkit: staff survey. Chicago (IL): American Medical Association (AMA); 2012 Jan. 4 p.

Measure Availability

Source available from the University of Colorado Center for Bioethics and Humanities Web site .

For more information, contact the University of Colorado Center for Bioethics and Humanities at Fulginiti Pavilion for Bioethics and Humanities – Mailstop B137, 13080 E. 19th Avenue, Room 201, Aurora, CO 80045; Phone: 303-724-6997; Fax: 303-724-3997; E-mail: CCAT@ucdenver.edu; Web site: www.ucdenver.edu .

Companion Documents

The following are available:

> C-CAT sampling and analysis guide. Chicago (IL): American Medical Association (AMA); 2011 Aug. 5 p.
> An Ethical Force Program™ consensus report: improving communication--improving care. Chicago (IL): American Medical Association (AMA); 2006. 144 p. This document is available from the University of Colorado Center for Bioethics and Humanities Web site .

For more information, contact the University of Colorado Center for Bioethics and Humanities at Fulginiti Pavilion for Bioethics and Humanities – Mailstop B137, 13080 E. 19th Avenue, Room 201, Aurora, CO 80045; Phone: 303-724-6997; Fax: 303-724-3997; E-mail: CCAT@ucdenver.edu; Web site: www.ucdenver.edu .

NQMC Status

This NQMC summary was completed by ECRI Institute on May 30, 2013. The information was verified by the measure developer on August 9, 2013.

This NQMC summary was updated by ECRI Institute on March 23, 2016. The information was not verified by the measure developer.

Copyright Statement

This NQMC summary is based on the original measure, which is subject to the measure developer's copyright restrictions.

The Communication Climate Assessment Toolkit (C-CAT) surveys are available for viewing online. You may download and use the surveys for research purposes at no cost. If you would like to use the C-CAT for a formal, benchmarked organization assessment, send an email to ccat@ucdenver.edu and we will contact you with a trained C-CAT consultant. Qualified C-CAT consultants will help you use the surveys for your organization assessment, provide benchmarking data and offer tailored guidance for improvement.

Production

Source(s)

Communication climate assessment toolkit: adult patient survey. Aurora (CO): University of Colorado-Center for Bioethics & Humanities; 2015. 5 p.

Communication climate assessment toolkit: pediatric patient (parents/guardians complete) survey. Aurora (CO): University of Colorado-Center for Bioethics & Humanities; 2015. 4 p.

Communication climate assessment toolkit: staff survey. Aurora (CO): University of Colorado-Center for Bioethics & Humanities; 2015. 4 p.

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