

CollaboRATE Shared Decision-Making Tool for Outpatient and Ambulatory Surgery Patients

Evidence Document

April 2025

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1. Measure Introduction

1.1 Measure Overview

This patient-reported outcome-based performance measure (PRO-PM) aims to improve patient-centered care quality, specifically shared decision-making (SDM), for beneficiaries undergoing outpatient and ambulatory surgeries. This measure assesses utilization of the CollaboRATE Shared Decision-Making Tool (CollaboRATE) at the facility level to encourage use of SDM in the preoperative visit. CollaboRATE is a 3-item survey (Appendix 1), designed and tested to be completed in under 30 seconds,¹ that assesses patients' perceptions of the quality of SDM in a clinical setting. CollaboRATE has undergone validation testing in multiple settings, including for use in surgery. It is endorsed for use by the National Quality Forum (NQF) for both the inpatient hospital and outpatient settings.² Finally, as discussed later in this document, the American College of Surgeons (ACS) has assessed its validity for use in a PRO-PM against other SDM tools through our own sources and analysis and found that it is the most acceptable, feasible, and capable of evaluating the quality of SDM for its utility in this context. This initial measure will require ambulatory and outpatient surgical centers to utilize the CollaboRATE tool to promote SDM in elective surgery. Future iterations of the measure may require public reporting of the levels of SDM quality through use of validated top box scoring discussed later in this document, and it may eventually be used in the pay-for-performance system.

CollaboRATE is just one tool that exists for assessing levels of shared decision-making. In 2020, the ACS undertook a multi-year project to develop the optimal PRO-PM to assess SDM in the ambulatory and outpatient setting as described below.

1.2 Measure Importance and Use

The need to expand quality measurement in the ambulatory and outpatient setting drove the ACS' decision to put forth this measure. In these settings, SDM, specifically the decision whether or not to undergo surgery, is critically important. In 2024, there were seven generalized quality measures and seven specialty-specific quality measures within the Ambulatory Surgery Center Quality Reporting Program (ASCQR). Many of these measures assess exceedingly rare outcomes in ambulatory surgery, such as hospital transfer, patient burns, patient falls, and never events. In 2024, rates of these complications were 0.811, 0.016, 0.134, and 0.026 per 1,000 patients, respectively.³ The Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems and the Information Transfer surveys assesses patients understanding of key information about their recovery and care experience, but these surveys do not assess the

quality of Shared Decision Making. In fact, none of the currently included measures assess the quality of the preoperative discussion or the depth of the decision to undergo surgery.

Shared decision-making is a model that blends patient autonomy with provider expertise. It avoids the pitfalls of paternalism, which is strongly grounded in reality but may fail to account for validly-held patient belief systems and preferences. Shared decision-making also avoids the opposite pitfalls of a completely patient-driven informed decision-making model, which may result in misinformation from commercial and other sources.⁴ Prior research has demonstrated that SDM is associated with improved patient satisfaction, health outcomes, and reduced wasteful healthcare utilization.⁵⁻⁹ CMS has previously required SDM for diagnostics, such as lung cancer screening,¹⁰ use by accountable care organizations,¹¹ and specific cardiovascular procedures.¹²

The short nature of the tool, as well as the extensive prior testing, speaks to CollaboRATE's feasibility of use and implementation. Previous studies have administered it via regular mail,¹³⁻¹⁴ email,¹³ computer or web interface,¹⁵⁻¹⁶ telephone interviews,^{13-14,16} SMS text messages,¹⁶ paper surveys,¹⁶ and electronic health record integration.¹⁶ It has been developed in 11 different languages, as well as for use in pediatrics and patients with special considerations, such as those with proxies or who are unable to speak for themselves.¹⁷ The CollaboRATE OAS Administration-PM is designed to first focus on the administration of the CollaboRATE tool to patients preparing for surgical procedures in the outpatient and ambulatory setting. The ACS intends to develop future iterations of this measure to evaluate patient responses that can be used to assess the performance of these facilities in shared decision-making.

Although initially developed for use in the outpatient medical setting, CollaboRATE has been studied in outpatient and ambulatory bariatric surgery,^{13,18} orthopedic surgery,^{14,19} neurosurgery,²⁰ pediatric ENT,²¹ and gynecological oncology²²—ideally as soon as possible after shared decision-making occurs.

2. Methods – The methods described in this document are contained in two peer-reviewed publications

2.1 Overview –

With support from the Agency for Healthcare Research and Quality (AHRQ), the ACS conducted a multisite study involving 65 U.S. hospitals and more than 30,000 patients to develop and test PRO-PMs using the CollaboRATE tool and the 9-item Shared Decision-Making Questionnaire (SDM-Q-9). **Validity and reliability analyses revealed that the facility-level CollaboRATE PRO-PM was most acceptable, feasible, and capable of evaluating the quality of SDM.** Risk factor analysis through multivariable regression

demonstrated several significant risk factors of inadequate SDM, but risk adjustment did not improve the reliability of either candidate CollaboRATE or SDM-Q-9 PRO-PM's.

2.2 Data Sources

This analysis used data from the ACS National Surgical Quality Improvement Program (NSQIP) Patient-Reported Outcomes Measures Demonstration Project. Between 2020 and 2023, patients undergoing elective surgical procedures at 65 sites completed six patient-reported outcome measures (PROMs).²³ Two of these PROMs, the CollaboRATE tool and SDM-Q-9 tools, were specifically geared towards assessing quality of SDM. PROMs were administered electronically using a customized version of the IQVIA Connection Platform (IQVIA, Durham, North Carolina).²³

2.3 Measure Cohort: Denominator

The CollaboRATE OAS Administration PM submitted for consideration in the 2026 HOPD and ASCQR programs has a denominator statement of all eligible patients scheduled for and who undergo an ambulatory or outpatient surgical procedure during the reporting period. This is a highly feasible adaptation of the CollaboRATE PRO-PM which will measure compliance with survey distribution while ASC's and HOPD's adjust their care processes to incorporate optimal survey administration.

In the studies conducted by the ACS, the denominator of the CollaboRATE PRO-PM was all eligible patients who completely answered all three survey questions. In the first iteration of the CollaboRATE OAS Administration-PM, the denominator statement will be the total number of patients who undergo surgery at a facility. The SDM-Q-9 PRO-PM denominator was the number of patients who completed the entire SDM-Q-9 survey.

2.4 Measure Outcome: Numerator

The CollaboRATE OAS Administration PM submitted for consideration in the 2026 HOPD and ASCQR programs has a numerator statement containing the number of patients who were administered the CollaboRATE PRO tool at any point before the surgical procedure. This is a highly feasible adaptation of the CollaboRATE PRO-PM which will measure compliance with survey distribution. This represents the first step towards quantifying levels of SDM in future iterations of this measure while ASC's and HOPD's adjust their care processes to incorporate optimal survey administration.

In the studies conducted by the ACS, the numerator of the CollaboRATE PRO-PM was all patients who gave top scores (rated as a 9 on a 0-9 scale) for all survey questions. In the first iteration of the CollaboRATE OAS Administration-PM, the numerator statement will be the total number of patients who are offered the CollaboRATE survey preoperatively. The

SDM-Q-9 PRO-PM numerator was the number of patients reporting a score greater than the 50th or 75th percentiles in the studied group.

2.5 Risk Adjustment

Candidate performance measures were evaluated for reliability both in risk-adjusted and non-risk-adjusted forms. Risk adjustment factors included patient age, patient sex, response mode, and preoperative predicted risk of surgical complications. Risk factors were identified through multivariable regression modeling against poor SDM status.

2.6 Calculation of Measure Score

The CollaboRATE PRO-PM's were calculated at both the facility and the surgeon level. The facility level was demonstrated better reliability and therefore is how the CollaboRATE OAS Administration-PM will be aggregated. In the study groups, the measure was scored as the proportion patients at the facility (or surgeon) level who gave maximum scores on the CollaboRATE survey tool.

2.7 Measure Testing

The CollaboRATE and SDM-Q-9 tools were compared in this study to determine the performance measure with the highest levels of validity for assessing quality of SDM. Three statistics were calculated to assess the reliability and validity of the CollaboRATE SDM PRO-PM and the SDM-Q-9 PRO-PM: median reliability of hospitals and surgeons, proportions of hospitals and surgeons achieving reliability ≥ 0.7 , and proportions of hospitals and surgeons achieving reliability ≥ 0.4 . Finally, the projected minimum sample sizes necessary to achieve reliability ≥ 0.7 and ≥ 0.4 for each candidate performance measure were calculated. Each of these statistics' responses to addition of risk adjustment, correction for nonresponse bias, and among the ambulatory subgroup were also calculated. We discuss the results of the ambulatory subgroup below, as this is the cohort applicable to the measure under consideration.

3. Results

3.1 Measure Cohort

Of the 130,365 patients administered PROMs as a part of the ACS PROMs Demonstration Project, 31,003 patients responded to the CollaboRATE measure, a response rate of 23.8%. The respondents represented a diverse group with over 20% minority representation. Patients were slightly more likely to be privately insured, followed by Medicare (46.2% and 45.8% respectively), and patients were most likely to follow up via email as opposed to SMS text message (88.3%). Of patients in the sample, 81% underwent an ambulatory procedure, and the median predicted risk for any complications was 6%.

Table 1 – Cohort Characteristics

Characteristic	Respondents to CollaboRATE (n = 31,003)	Respondents to SDM-Q-9 (n = 28,960)
Age, y, mean (SD)	62.6 (13.3)	62.7 (13.2)
Female sex, n (%)	18,814 (60.7%)	17,508 (60.5%)
Race, n (%)		
– Asian	806 (2.6%)	745 (2.6%)
– Black	3,490 (11.3%)	3,213 (11.1%)
– White	24,667 (79.5%)	23,099 (79.7%)
– Other	2,040 (6.6%)	1,903 (6.6%)
Hispanic ethnicity, n (%)	1,533 (4.9%)	1,431 (4.9%)
Insurance status, n (%)		
– Medicaid	1,389 (4.5%)	1,275 (4.4%)
– Medicare	14,210 (45.8%)	13,294 (45.9%)
– Commercial	14,320 (46.2%)	13,371 (46.2%)
– Self-pay	230 (0.7%)	215 (0.7%)
– Other	854 (2.8%)	805 (2.8%)
Response mode, n (%)		
– Email	27,383 (88.3%)	25,633 (88.5%)
– SMS text message	3,620 (11.7%)	3,327 (11.5%)
Ambulatory procedures, n (%)	25,102 (81.0%)	23,387 (80.8%)
Predicted risk for any complications*, %, median (IQR)	6.0 (4.3–8.9)	6.0 (4.3–9.0)
Any complications*, n (%)	2,398 (7.7%)	2,225 (7.7%)
Top box score, n (%)	19,756 (63.7%)	N/A
≥50th percentile, n (%)	N/A	15,780 (54.5%)
≥75th percentile, n (%)	N/A	12,209 (42.2%)

It is important to note that patients were administered a total of 6 PROMs (although CollaboRATE and the SQM-Q-9 were the only two measuring SDM and therefore are the only ones discussed in this document) as a part of this project with a total of 34 total items assessed. This substantially increases the patient response burden beyond what has been seen in previous work when the CollaboRATE survey has been studied alone, and it achieved response rates as high as 86% in some settings.²⁴⁻²⁶

Of the 65 hospitals included in the analysis, the median number of responses to the CollaboRATE survey per hospital was 425 (IQR 264-570). There were 977 surgeons with at least 10 responses to the CollaboRATE tool. The median number of responses for these surgeons was 19 (IQR 13-30).

3.2 Measure Score

Of all patients, 63.7% reported top-box scores for all questions on the CollaboRATE Survey as seen in Table 1. In other words, a full third of patients reported less than adequate SDM. The median number of responses to SDM-Q-9 per hospital was 388 (IQR 242-530) and the median hospital level performance score was 64.3% (IQR 61.3-68.6%; CV 8.2) when the 50th percentile cutoff for the SDM-Q-9 was used and 42.5% (IQR 40.3-46.5%; CV 11.5) when the 75th percentile was used.

3.3 Risk Model

Analysis demonstrated that male, Asian, non-Hispanic, and older patients were at higher risk of reporting inadequate levels of SDM. Differences were also observed between specialties, gender of operating surgeon, hospital type, and insurance status. Patients who experienced complications were more likely to report inadequate SDM (Table 2).

Despite the variable risks at the patient level for inadequate SDM, CollaboRATE's ability to reliably distinguish as a performance measure did not demonstrate significant improvement when risk-adjusted for age, sex, response type, and preoperative likelihood of any complication (Table 3, Table 4). Due to this inability to improve reliability with risk stratification, further research needs to be done before incorporating risk adjustment into a performance measure, and at this time no risk adjustment is recommended.

Performance measures are often risk-adjusted to ensure fair comparisons when performance can be influenced by factors beyond the control of the subjects being evaluated. Whether performance measures based on patient-reported SDM should be risk-adjusted remains debated and is a conceptual question.²⁷⁻²⁸ For instance, it is not clear whether the presence of a comorbidity needs to be considered when asking the patient's perception of being sufficiently informed and involved in the decision-making of their care. Since the essence of SDM is to engage each patient fully in their care decisions, it is reasonable to expect sufficient levels of SDM regardless of patient sociodemographics, social determinants, or clinical complexity. **Risk adjustment in this context could inadvertently lower the standards for certain groups, undermining efforts toward equitable patient care.** Upholding a consistent standard without risk adjustment emphasizes the commitment to equitable, patient-centered care and encourages surgeons to strive for excellence in SDM across all patients.

Table 2 – Risk Factors Associated with Inadequate Levels of SDM

Variable	Comparison	CollaboRATE OR (95% CI)	CollaboRATE P value	SDM-Q-9 OR (95% CI)	SDM-Q-9 P value
Patient Characteristics					
Age quartiles	55-64 vs. <55	1.03 (0.96, 1.11)	0.07	1.22 (1.13, 1.31)	<.001
	65-72 vs. <55	0.95 (0.87, 1.05)		1.26 (1.15, 1.38)	
	>72 vs. <55	1.04 (0.94, 1.15)		1.44 (1.31, 1.59)	
Sex	Male vs. Female	1.22 (1.15-1.29)	<0.001	0.98 (0.93-1.04)	0.48
Race	Asian vs. White	1.25 (1.07-1.46)	0.008	1.00 (0.85-1.17)	<.001
	Black vs. White	0.95 (0.88-1.04)		1.35 (1.24-1.47)	
	Other vs. White	1.09 (0.98-1.21)		1.17 (1.05-1.31)	
Hispanic ethnicity	Yes vs. No	0.94 (0.83-1.07)	0.32	1.06 (0.93-1.19)	0.39
Insurance type	Medicaid vs. Commercial	1.20 (1.06-1.35)	0.01	1.19 (1.05-1.34)	<.001
	Medicare vs. Commercial	1.08 (1.01-1.15)		1.18 (1.11-1.26)	
	Other vs. Commercial	1.01 (0.87-1.18)		0.93 (0.80-1.08)	
	Self-pay vs. Commercial	1.00 (0.75-1.34)		1.06 (0.80-1.41)	
Ambulatory status	Non-ambulatory vs. Ambulatory	1.11 (1.03-1.20)	0.009	1.14 (1.05-1.23)	0.002
Response mode	Email vs SMS	0.98 (0.90-1.08)	0.72	0.95 (0.87-1.04)	0.28
Preoperative risk quintiles	3.9-5.1 vs <3.9%	1.00 (0.92-1.09)	0.41	1.01 (0.93-1.10)	0.51
	5.2-6.8 vs <3.9%	0.95 (0.87-1.03)		0.95 (0.88-1.04)	
	6.9-10.4% vs <3.9%	1.02 (0.93-1.11)		0.99 (0.90-1.08)	
	>10.4 vs <3.9%	1.01 (0.91-1.12)		0.95 (0.86-1.05)	
Any Complication	Yes vs. No	1.33 (1.21-1.46)	<0.001	1.32 (1.20-1.45)	<.001

Surgeon Characteristics					
Surgeon sex	Male vs. Female	1.11 (1.02-1.20)	0.02	1.12 (1.04-1.20)	0.004
Years in practice quintiles	13-16 vs. <12 years	1.09 (0.99-1.19)	<0.001	1.11 (1.02-1.21)	0.14
	17-23 vs. <12 yrs	1.20 (1.10-1.31)		1.09 (1.01-1.19)	
	24-31 vs. <12 yrs	1.11 (1.02-1.21)		1.05 (0.96-1.14)	
	>31 vs. <12 yrs	1.18 (1.07-1.29)		1.06 (0.97-1.16)	
Surgical specialty	CT vs. General Surgery	1.44 (1.16-1.79)	<0.001	1.17 (0.94-1.44)	<.001
	NSGY vs. General Surgery	1.17 (1.02-1.33)		1.12 (0.99-1.27)	
	Ob/Gyn vs. General Surgery	0.83 (0.75-0.92)		0.86 (0.78-0.95)	
	Orthopedic vs. General Surgery	1.39 (1.28-1.52)		1.25 (1.15-1.35)	
	ENT vs. General Surgery	1.04 (0.86-1.25)		1.11 (0.93-1.33)	
	Plastic vs. General Surgery	0.98 (0.83-1.15)		0.81 (0.70-0.95)	
	Urology vs. General Surgery	1.31 (1.18-1.45)		1.12 (1.01-1.24)	
	Vascular vs. General Surgery	1.37 (1.15-1.63)		1.25 (1.05-1.49)	
Hospital Characteristics					
Medicaid patients (%)	-	1.11 (0.72-1.71)	0.57	1.08 (0.76-1.55)	0.67
Teaching hospital	Yes vs. No	1.03 (0.86-1.24)	0.73	1.10 (0.94-1.29)	0.24
Hospital bed count	100-499 beds vs. 500+ beds	1.03 (0.92-1.15)	0.8	1.03 (0.94-1.13)	0.77
	<100 beds vs. 500+ beds	1.10 (0.82-1.48)		0.98 (0.76-1.27)	
Urbanicity	Rural vs Urban	1.05 (0.85-1.30)	0.63	1.15 (0.96-1.38)	0.13
Rural referral center	Yes vs. No	1.17 (1.04-1.31)	0.01	1.15 (1.05-1.27)	0.01
ACS CoC accredited	Yes vs No	0.99 (0.86-1.14)	0.91	1.02 (0.91-1.15)	0.7

JCAHO accredited	Yes vs. No	1.09 (0.95-1.25)	0.2	1.05 (0.93-1.17)	0.43
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3.4 Reliability

surgeons and facilities

Measure reliability was calculated using logistic mixed-effects regression at both the facility and surgeon levels to generate signal-to-noise ratios. As demonstrated in Tables 3 and 4, reliability was greatly improved when the performance measure was calculated at the facility level as compared to the surgeon level (0.78 compared with 0.44). The addition of risk adjustment marginally worsened reliability in both groups, and correction for non-response bias improved reliability. In both groups, the ambulatory subgroup demonstrated improved reliability over the general group. The ambulatory subgroups were adjusted for non-response bias.

When assessing the numbers of surgeons and facilities that achieved a reliability of at least 0.70, the facility level clearly dominated. The number of patients required for a reliability of 0.70 at the facility level was 192. Eighty percent of participating facilities (52) achieved sample sizes of 192 patients (Table 3). The number of patients required for a reliability threshold of 0.7 at the surgeon level was 47. Only 8.9% of participating surgeons achieved a response rate of 47 patients (Table 4). This supports CollaboRATE as both more feasible and valid when aggregated at the facility level as compared to the surgeon level. A difference was also sustained when tested at the 0.4 level with facilities achieving this threshold 95.4% of the time, and surgeons achieving this threshold only 72.5% of the time. It is more feasible for the facility level to achieve high levels of responses than for an individual surgeon (as demonstrated by the median number of responses, 425 for facilities, and 19 for surgeons), explaining the differences. Reliability was found to be greater for the CollaboRATE PRO-PM's than for the SDM-Q-9 PRO-PM's.

Table 3: Reliability Calculations for Candidate PRO-PM's Aggregated at the Facility Level

Measure & Subgroup	Operation Types	Risk Adjustment	Nonresponse Correction	Reliability, median (IQR)	Reliability ≥ 0.70 , n (%)	Reliability ≥ 0.40 , n (%)	Projected Sample Size ≥ 0.70	Projected Sample Size ≥ 0.40
CollaboRATE – Top Box								
	All	No	No	0.78 (0.69–0.83)	48 (73.9%)	62 (95.4%)	278	80
	All	Yes	No	0.77 (0.68–0.82)	48 (73.9%)	62 (95.4%)	292	84
	All	No	Yes	0.81 (0.72–0.85)	52 (80.0%)	62 (95.4%)	235	68
	Ambulatory only	No	Yes	0.81 (0.73–0.85)	52 (80.0%)	62 (95.4%)	192	55
SDM-Q-9 – 50th percentile or higher								
	All	No	No	0.68 (0.58–0.74)	31 (47.7%)	59 (90.8%)	430	123
	All	Yes	No	0.67 (0.55–0.73)	28 (43.1%)	59 (90.8%)	454	130
	All	No	Yes	0.69 (0.58–0.75)	31 (47.7%)	59 (90.8%)	415	119
	Ambulatory only	No	Yes	0.69 (0.59–0.74)	31 (47.7%)	60 (92.3%)	348	100
SDM-Q-9 – 75th percentile or higher								
	All	No	No	0.69 (0.58–0.75)	31 (47.7%)	59 (90.8%)	416	119
	All	Yes	No	0.66 (0.54–0.72)	22 (33.9%)	57 (87.7%)	478	136
	All	No	Yes	0.73 (0.62–0.78)	38 (58.5%)	61 (93.9%)	352	101
	Ambulatory only	No	Yes	0.71 (0.61–0.76)	34 (52.3%)	60 (92.3%)	319	92

Table 4: Reliability Calculations for Candidate PRO-PM's Aggregated at the Surgeon Level

Measure & Subgroup	Operation Types	Risk Adjustment	Nonresponse Correction	Reliability, median (IQR)	Reliability ≥ 0.70 , n (%)	Reliability ≥ 0.40 , n (%)	Projected Sample Size ≥ 0.70	Projected Sample Size ≥ 0.40
CollaboRATE – Top Box								
	All	No	No	0.44 (0.35–0.56)	61 (6.2%)	604 (61.8%)	57	17
	All	Yes	No	0.41 (0.33–0.54)	40 (4.1%)	529 (54.2%)	64	19
	All	No	Yes	0.49 (0.41–0.61)	105 (10.8%)	759 (77.7%)	46	13
	Ambulatory only	No	Yes	0.47 (0.39–0.59)	71 (8.9%)	576 (72.5%)	47	14
SDM-Q-9 – 50th percentile or higher								
	All	No	No	0.34 (0.27–0.45)	17 (1.9%)	317 (34.5%)	85	24
	All	Yes	No	0.33 (0.25–0.43)	11 (1.2%)	283 (30.8%)	92	26
	All	No	Yes	0.43 (0.35–0.54)	44 (4.8%)	549 (59.8%)	59	17
	Ambulatory only	No	Yes	0.41 (0.33–0.52)	34 (4.6%)	382 (51.8%)	60	17
SDM-Q-9 – 75th percentile or higher								
	All	No	No	0.30 (0.23–0.40)	8 (0.9%)	229 (25.0%)	104	30
	All	Yes	No	0.27 (0.20–0.36)	4 (0.4%)	175 (19.1%)	120	35
	All	No	Yes	0.38 (0.30–0.49)	23 (2.5%)	413 (45.0%)	72	21
	Ambulatory only	No	Yes	0.37 (0.31–0.49)	23 (3.1%)	313 (42.5%)	68	19

3.5.1 Measure Face Validity

To validate the use of CollaboRATE as a participation performance measure, the ACS conducted a Modified Delphi panel with 12 experts in surgical leadership sampled from attendees of the 2025 ACS Leadership and Advocacy Summit. In attendance were

three general surgeons, a trauma surgeon, two colorectal surgeons, an endocrine surgeon, a pediatric surgeon, a urologist, a surgical oncologist, a neurosurgeon, and a bariatric surgeon. Participants listened to a brief presentation on the structure of the CollaboRATE tool, as well as prior research that has been done to validate its use in surgical settings. Use of the CollaboRATE tool as part of a PRO-PM for inclusion in the ASCQR and Hospital Outpatient Department (HOPD) programs as a pay-for participation measure was discussed. After discussion, participants were anonymously polled on whether they believed that this PRO-PM measure should be submitted for inclusion in either the ASCQR, the HOPD, or both programs on a scale of 0 – 9. Mean scores after the initial survey demonstrated high support for the measure, with an average score of 7.42 for the ambulatory program, and 7.58 for outpatient program, and a mode of 7 and 8 respectively.

After anonymous voting, a group discussion was held to discuss and deliberate on the different strengths and weaknesses of the measure. After this round of discussions, another anonymous survey was distributed with the measure scoring 7.75 on average for both the ambulatory and outpatient quality reporting programs. The mode also increased to 9 for both programs. At final voting, 83% of participants felt that the CollaboRATE OAS Administration-PM should be included in both the ASCQR and HOPD programs, with 17% of respondents neither in favor nor in opposition to the measure. This level of support exceeds the commonly reported 70% threshold for Delphi Panel Consensus.

3.5.2 Construct validity

CollaboRATE was found to behave as expected for a measure of shared decision-making when compared between different surgical procedures and specialties (Table 2). Higher patient preoperative risk for complications was not associated with better SDM. One possible explanation is that surgeons appropriately account for preoperative risk factors for surgical morbidity, such as functional status and comorbid conditions, during their surgical consultations to ensure care plans align with patient priorities. In contrast, SDM ratings varied significantly by procedure group, with the highest rates of inadequate SDM reported for appendectomies in contrast to operations like hysterectomies and breast surgeries. The higher SDM ratings in these procedures may reflect the communication practices of specialties such as obstetrics/gynecology and plastic surgery, which were associated with higher adequate SDM. These findings are consistent with prior research that has demonstrated surgeons may engage more effectively in SDM for operations with less obvious benefit for the patient.²⁹

References:

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Appendix Materials

Appendix 1:

CollaboRATE Survey Questions and scoring:

1. How much effort was made to help you understand your health issues?
2. How much effort was made to listen to the things that matter most to you about your health issues?
3. How much effort was made to include what matters most to you in choosing what to do next?

The short, easy-to-understand answers of CollaboRATE are graded on a scale of 0 – 9 and contribute to its usefulness in clinical quality assessment.³⁰