



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

NQF #: 1741

Corresponding Measures:

Measure Title: Consumer Assessment of Healthcare Providers and Systems (CAHPS)[®] Surgical Care Survey Version 2.0

Measure Steward:

sp.02. Brief Description of Measure: The following 6 composites and 1 single-item measure are generated from the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Surgical Care Survey. Each measure is used to assess a particular domain of surgical care quality from the patient's perspective.

Measure 1: Information to help you prepare for surgery (2 items)

Measure 2: How well surgeon communicates with patients before surgery (4 items)

Measure 3: Surgeon's attentiveness on day of surgery (2 items)

Measure 4: Information to help you recover from surgery (4 items)

Measure 5: How well surgeon communicates with patients after surgery (4 items)

Measure 6: Helpful, courteous, and respectful staff at surgeon's office (2 items)

Measure 7: Rating of surgeon (1 item)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surgical Care Survey (S-CAHPS) is a standardized survey instrument that asks patients about their experience before, during and after surgery received from providers and their staff in both inpatient and outpatient (or ambulatory) settings. S-CAHPS is administered to adult patients (age 18 and over) that had an operation as defined by CPT codes (90 day globals) within 3 to 6 months prior to the start of the survey.

The S-CAHPS expands on the CAHPS Clinician & Group Survey (CG-CAHPS), which focuses on primary and specialty medical care, by incorporating domains that are relevant to surgical care, such as sufficient communication to obtain informed consent, anesthesia care, and post-operative follow-up and care coordination. Other questions ask patients to report on their experiences with office staff during visits and to rate the surgeon.

The S-CAHPS survey is sponsored by the American College of Surgeons (ACS). The survey was approved as a CAHPS product in early 2010 and the Agency for Healthcare Research and Quality (AHRQ) released version 1.0 of the survey in the spring of 2010. The S-CAHPS survey Version 2.0 was subsequently endorsed by NQF in June 2012 (NQF #1741). The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at <https://cahps.ahrq.gov/surveys-guidance/cg/about/index.html>. Surgeons may customize the S-CAHPS survey by adding survey items that are specific to their patients and practice. However, the core survey must be

used in its entirety in order to be comparable with other S-CAHPS data. The S-CAHPS survey is available in English and Spanish.

The 6 composite measures are made up of the following items:

The 1 single item measure (Measure 7) is (Q35): Using any number from 0 to 10, where 0 is the worst surgeon possible and 10 is the best surgeon possible, what number would you use to rate all your care from this surgeon?

Measure 1: Information to help you prepare for surgery (2 items)

Q3. Before your surgery, did anyone in this surgeon's office give you all the information you needed about your surgery?

Q4. Before your surgery, did anyone in this surgeon's office give you easy to understand instructions about getting ready for your surgery?

Measure 2: How well surgeon communicates with patients before surgery (4 items)

Q9. During your office visits before your surgery, did this surgeon listen carefully to you?

Q10. During your office visits before your surgery, did this surgeon spend enough time with you?

Q11. During your office visits before your surgery, did this surgeon encourage you to ask questions?

Q12. During your office visits before your surgery, did this surgeon show respect for what you had to say?

Measure 3: Surgeon's attentiveness on day of surgery (2 items)

Q15. After you arrived at the hospital or surgical facility, did this surgeon visit you before your surgery?

Q17. Before you left the hospital or surgical facility, did this surgeon discuss the outcome of your surgery with you?

Measure 4: Information to help you recover from surgery (4 items)

Q26. Did anyone in this surgeon's office explain what to expect during your recovery period?

Q27. Did anyone in this surgeon's office warn you about any signs or symptoms that would need immediate medical attention during your recovery period?

Q28. Did anyone in this surgeon's office give you easy to understand instructions about what to do during your recovery period?

Q29. Did this surgeon make sure you were physically comfortable or had enough pain relief after you left the hospital or surgical facility where you had your surgery?

Measure 5: How well surgeon communicates with patients after surgery (4 items)

Q31. After your surgery, did this surgeon listen carefully to you?

Q32. After your surgery, did this surgeon spend enough time with you?

Q33. After your surgery, did this surgeon encourage you to ask questions?

Q34. After your surgery, did this surgeon show respect for what you had to say?

Measure 6: Helpful, courteous, and respectful staff at surgeon's office (2 items)

Q36. During these visits, were clerks and receptionists at this surgeon's office as helpful as you thought they should be?

Q37. During these visits, did clerks and receptionists at this surgeon's office treat you with courtesy and respect?

1b.01. Developer Rationale: All of the measures submitted to NQF for endorsement share the main objective of the S-CAHPS survey, which is to measure aspects of surgical quality that are important to consumers and for which consumers are the best source of information. At the same time, consistent with the survey, the measures aim to directly benefit a variety of users, including: patients, practice groups, health plans, insurers, and specialty boards. Each group has a need for information regarding the quality of surgeons and surgical care.

The S-CAHPS survey measures patients' perceptions of their experiences with pre-, during and post-surgical care. The survey addresses issues relevant to surgical care, such as informed consent, communication, clear and helpful information, anesthesia care, office staff helpfulness, and post-operative follow-up.

To offer surgical patients and surgeons valid and reliable information on patient experience of care, the American College of Surgeons (ACS), in partnership with other surgical and anesthesia organizations, sponsored the development of the S-CAHPS survey. The S-CAHPS survey is a patient experience-of-care survey measure specifically tailored for surgical patients. The S-CAHPS survey was developed by working with patients to report on the full experience of surgical care, including their experience with the surgeon, the anesthesiologist, and the facility. Qualitative research (i.e., focus groups, cognitive testing, literature review) prior to field testing and focus groups following the main field test contributed to the development of the final composite measures. The data gathered through S-CAHPS survey data can assist consumers in identifying a high-quality surgeon and help surgeons to better understand and ultimately improve patient care.

To capture and ascertain the major domains surrounding the consumers' view of quality surgical care, the American Institutes for Research performed a literature review prior to developing the surgical CAHPS instrument. Using four literature databases: Medline, PsychInfo, CINAHL, and Evidence-Based Medicine Review, AIR reviewed 930 abstracts. These abstracts were narrowed from certain search terms and limitations. AIR asked the Surgical Quality Alliance (SQA) Technical Advisory Panel (TAP) members to provide input and guidance in these terms and limitations. The TAP included 21 members from various surgery and anesthesiology specialty societies, each having technical expertise in the topic of surgical care. The AIR research analyst then classified each abstract as relevant, possibly relevant, and not relevant.

From that point on, only the research analyst's "relevant" and "possibly relevant" classifications were reviewed by the project director. From this abstract review method, 37 abstracts were chosen to review in full. In addition, one article was added from an SQA Technical Advisory Panel (TAP) member. The 38 articles reviewed indicated 14 domains, or primary issues, of surgical patient care experience from a patient's perspective: information/education, interpersonal manner, pain, emotional support, accessibility/convenience, technical quality of care, efficacy/outcomes of care, availability, environment, customization/personalized care, patient involvement in care, continuity of care, overall satisfaction, and finances. These results guided the development of the surgical survey based on relevance to quality and to consumers and the ability of consumers to act as reliable reporters of the domain.

In addition, American Institutes for Research conducted six focus groups to identify important quality issues inherent in patients' experiences of surgical care. The results of the focus groups are included in Attachment D Main 1c5 Surgical CAHPS Focus Groups_2nd Round_2010.pdf. In total, 49 people participated in the focus groups, all of whom were 18 years of age or older and had undergone a surgical procedure billable with a 90-day global fee within the last 7 months. The groups were diverse both demographically and in the type of surgery. For recruiting the additional two groups of patients with more complex surgeries, each participant had their surgery in a hospital and stayed overnight for at least one night.

After the focus groups were conducted, the AIR project director, senior research analyst, and research analyst examined the notes and focused in on each of the above issues. They gathered recurring themes and issues into a report of results, used to develop insights about what patients feel characterizes quality surgical care. The three main domains were surgeon's interpersonal skills and behaviors, surgeon's expertise/technical competence, and surgeon's skill in communicating or providing health information and patient education. The results of the focus groups and the surgical patients' experiences of care ultimately guided development of the surgical survey. Though patients rated technical skill of the surgeon as highly relevant to quality, it was determined that patients are not the best reporters of technical surgical expertise, so this was not included as a domain in the survey instrument. Additionally, based on the psychometric analysis and discussions within the Surgical Quality Alliance (SQA) Technical Advisory Panel (TAP), ACS did not recommend the Anesthesia Care items as a reporting composite. While ACS believes these items should remain in the survey because anesthesia care is an important factor in the surgical patient's experience of care, the Anesthesiologist works within the hospital system, and thus, the surgeon cannot adequately control the experiences between patient and anesthesiologist, and should not be measured on such.

sp.12. Numerator Statement: We recommend that S-CAHPS Survey items and composites be calculated using a top-box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses.

The top box numerator for the Overall Rating of Surgeon is the number of respondents who answered 9 or 10 for the item, with 10 indicating “Best provider possible”.

For more information on the calculation of reporting measures, see What’s Available for the CAHPS Surgical Care Survey: <https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/surgical/about/whats-available-surgical-care-survey.pdf>

Also see Patient Experience Measures from the CAHPS Surgical Care Survey Document 409 obtained by going to: <https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html>

Also, for more information on the calculation of reporting measures, see How to Report Results of the CAHPS Clinician & Group Survey, available at <https://cahps.ahrq.gov/surveys-guidance/cg/cgkit/HowtoReportResultsofCGCAHPS080610FINAL.pdf>.

sp.14. Denominator Statement: The measure’s denominator is the number of survey respondents. The target population for the survey is adult patients (age 18 and over) who had a major surgery as defined by Common Procedural Terminology (CPT) codes (90 day globals) within 3 to 6 months prior to the start of the survey.

Results will typically be compiled over a 12-month period.

For more information on the calculation of reporting measures, see Patient Experience Measures from the CAHPS Surgical Care Survey, available at <https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html>.

sp.16. Denominator Exclusions: The following are excluded when constructing the sampling frame:

- Surgical patients whose procedure was greater than 6 months or less than 3 months prior to the start of the survey.
- Surgical patients younger than 18 years old.
- Surgical patients who are institutionalized (put in the care of a specialized institution) or deceased.

Measure Type: Outcome: PRO-PM

sp.28. Data Source:

Instrument-Based Data

sp.07. Level of Analysis:

Clinician: Group/Practice

IF Endorsement Maintenance – Original Endorsement Date: 2012-05-01 01:31 AM

Most Recent Endorsement Date: 6/5/2018 3:02:15 PM

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

sp.03. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?:

1. Importance to Measure and Report

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

1ma.01. Indicate whether there is new evidence about the measure since the most recent maintenance evaluation. If yes, please briefly summarize the new evidence, and ensure you have updated entries in the Evidence section as needed.

[Response Begins]

Yes

[Response Ends]

Please separate added or updated information from the most recent measure evaluation within each question response in the Importance to Measure and Report: Evidence section. For example:

Current Submission:

Updated evidence information here.

Previous (Year) Submission:

Evidence from the previous submission here.

1a.01. Provide a logic model.

Briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient's health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

[Response Begins]

[Response Ends]

1a.02. Provide evidence that the target population values the measured outcome, process, or structure and finds it meaningful.

Describe how and from whom input was obtained.

[Response Begins]

[Response Ends]

1a.03. Provide empirical data demonstrating the relationship between the outcome (or PRO) and at least one healthcare structure, process, intervention, or service.

[Response Begins]

[Response Ends]

1b.01. Briefly explain the rationale for this measure.

Explain how the measure will improve the quality of care, and list the benefits or improvements in quality envisioned by use of this measure.

[Response Begins]

All of the measures submitted to NQF for endorsement share the main objective of the S-CAHPS survey, which is to measure aspects of surgical quality that are important to consumers and for which consumers are the best source of information. At the same time, consistent with the survey, the measures aim to directly benefit a variety of users, including: patients, practice groups, health plans, insurers, and specialty boards. Each group has a need for information regarding the quality of surgeons and surgical care.

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information/education, interpersonal manner, pain, emotional support, accessibility/convenience, technical quality of care, efficacy/outcomes of care, availability, environment, customization/personalized care, patient involvement in care, continuity of care, overall satisfaction, and finances. These results guided the development of the surgical survey based on relevance to quality and to consumers and the ability of consumers to act as reliable reporters of the domain.

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examined the notes and focused in on each of the above issues. They gathered recurring themes and issues into a report of results, used to develop insights about what patients feel characterizes quality surgical care. The three main domains were surgeon's interpersonal skills and behaviors, surgeon's expertise/technical competence, and surgeon's skill in communicating or providing health information and patient education. The results of the focus groups and the surgical patients' experiences of care ultimately guided development of the surgical survey. Though patients rated technical skill of the surgeon as highly relevant to quality, it was determined that patients are not the best reporters of technical surgical expertise, so this was not included as a domain in the survey instrument. Additionally, based on the psychometric analysis and discussions within the Surgical Quality Alliance (SQA) Technical Advisory Panel (TAP), ACS did not recommend the Anesthesia Care items as a reporting composite. While ACS believes these items should remain in the survey because anesthesia care is an important factor in the surgical patient's experience of care, the Anesthesiologist works within the hospital system, and thus, the surgeon cannot adequately control the experiences between patient and anesthesiologist, and should not be measured on such.

[Response Ends]

1b.02. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.

Include mean, std dev, min, max, interquartile range, and 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 (4b) under Usability and Use.

[Response Begins]

Performance data with the statistics requested are provided in the attached Excel file named "Attachment B Main 1b2 S-CAHPS_score_Tables.xlsx." The summary statistics at the practice site level (mean, SD, min, max, deciles) can be found in the worksheet tab titled "Summary Stats".

Performance data from a pilot study of the S-CAHPS in two surgical subspecialties is shown below. The pilot study was an IRB-approved secondary analysis conducted of S-CAHPS data collected by Duke Otolaryngology Head and Neck Surgery (OHNS, via web-based electronic data capture system) and University of Michigan Urology (GU, via postal mail) from 2011-2013. A total of 2695 adult patients were administered S-CAHPS within 4 weeks of surgery (1424 OHNS, 1271 GU). Survey content was separated into 6 composite scores and analyzed by %-top box scoring for separate and pooled data. A total of 727 patients completed the survey (n=303, 21.3% OHNS and n=424, 33.8% GU). Full survey completion rate for all rated questions was 62% OHNS and 72% GU. Composite top-box scores were similar between OHNS and GU except for Communication Pre-Operatively. As shown in the Table below, pooled overall surgeon rating was high (88% top-box scores, ranked 9-10 out of 10). The overall surgeon rating was most correlated with surgeon communication pre- and post-operatively, followed by information to recover from surgery. Differences in both surgical subspecialty and mode of administration yielded similar responses to S-CAHPS, but mailed GU survey yielded a higher response rate.

S-CAHPS Composite Top-Box Results from Lenherr et al. study

Composite % Top Box Pooled OHNS and GU (n=727)

Information to prepare for surgery 92%

Communication pre-operatively 92%

Surgeon's attentiveness day of surgery 84%

Information to recover from surgery 83%

Communication post-operatively 91%

Helpful, courteous and respectful staff 92%

Overall surgeon rating 88%

Citations:

Lenherr SM, DeCicco B., Cameron AP, Malaeb BS., Oldendorf AL, Stoffel JT, Karls EM, and Clemens JQ. The S-CAHPS

Survey in Urology. (in press) Urology Practice. Vol 2. Available online at
[http://www.urologypracticejournal.com/article/S2352-0779\(14\)00109-5/pdf](http://www.urologypracticejournal.com/article/S2352-0779(14)00109-5/pdf).

Schulz KA, Rhee JS, et al. (2012) Consumer Assessment of Healthcare Providers and Systems Surgical Care Surveys: Benefits and Challenges. Otolaryngology - Head and Neck Surgery. 147(4):671-7.

[Response Ends]

1b.03. If no or limited performance data on the measure as specified is reported above, 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. Include citations.

[Response Begins]

The CAHPS Surgical Care Survey was implemented by the American Academy of Otolaryngology (AAO) – Head and Neck Surgery from August 2010 through March 2011. The S-CAHPS was administered in four sites with a total of 14 surgeons. Two sites were academic medical centers, and the other two sites were community practices. A total of 354 surveys were collected across the three sites. An overall response rate of 39.9% was achieved with individual site response rates of 37.7%, 35.7% and 47.9% respectively. As can be seen in the table from Schulz et al., minimum scores at the surgeon level were quite low. The overall scores for Recovery Information and Surgeon Communication have much room for improvement.

Schmocker et al. used the S-CAHPS survey to determine which aspects of perioperative care were predictive of satisfaction with the surgeon. Their response rate was 45.3%. They found that on multivariable analysis, preoperative communication and attentiveness on the day of surgery were the most important determinants of overall surgeon rating. Lenherr et al. published the first experience and results of using S-CAHPS in urology. With a 33.8% response rate, their data suggested patient satisfaction with the surgeon is more influenced by postoperative communication and information. Jiang and Malkin used Lean A3 thinking to analyze S-CAHPS survey data to identify quality improvement opportunities. Care processes in their postoperative clinic were modified and they found improvement in their S-CAHPS survey scores on the domains that they targeted.

Below are several case studies of physician practices that have used the CAHPS survey to focus on and implement successful quality improvement interventions.

Five clinics in San Francisco improved the scores in communication after focusing on patients' most important concerns (Fisher and Gatewood, 2011). In Massachusetts, the Massachusetts General Physicians Organization implemented procedures for informing patients of waits, service recovery, physician communication and coaching, and staff huddles. These approaches coupled with education, training and recognition programs led to improved CG-CAHPS scores.

At the Dean Clinic in Wisconsin (over 800 medical staff in 60 locations), the service department shadowed staff and provided feedback. To improve consistency in service across all sites, the Clinic developed an orientation for all new employees on customer service expectations. They also offered ongoing training in the form of service workshops, videos, and Webinars, as well as targeted interventions for the lowest scoring offices. As a result, Dean Clinic's overall performance on the "Helpful, Courteous, and Respectful Office Staff" composite measure increased from 79 percent in 2011 to 83 percent in 2013 (AHRQ CAHPS Website).

In July 2014, The Robert Wood Johnson Foundation updated their inventory of CAHPS quality improvement resources. This document offers tools to support health care organizations in determining what they need to do to improve patient experience and how to implement those improvements. These resources are available for both ambulatory care settings and hospitals and can be found here: http://forces4quality.org/af4q/download-document/6540/Resource-12-125_inventory_of_pat_exp_improvement_resources_-_designed_-_revised_11.3.pdf.

Providers routinely use patient experience measures such as CAHPS to guide quality improvement (QI) efforts (Friedberg et al, 2011; Davies, Shaller et al., 2013). Friedberg et al (2011) found that physician groups commonly targeted improvement at access, communication with patients, and customer service by addressing office workflow, providing additional training for nonclinical staff, and adopting or enhancing an electronic health record.

Citations:

AHRQ CAHPS Website: Quality Improvement Reports and Case Studies accessible at https://www.ahrq.gov/cahps/quality-improvement/reports-and-case-studies/Case-Study_QI-Initiatives.html

Fisher T and Gatewood H. Improving patient experience: A hands on guide for safety net clinics. California Healthcare Foundation. 2011. Accessible at <http://www.chcf.org/>

[Response Ends]

1b.04. 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.

Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included. Include mean, std dev, min, max, interquartile range, and scores by decile. 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 (4b) under Usability and Use.

[Response Begins]

Top box scores from the adult survey by gender, race and by age category are provided in worksheets “Sum Stats Ethnicity”, “Sum Stats Age” and “Sum Stats Gender” in the attached Excel file named Attachment B Main 1b2 S-CAHPS_score_Tables.xlsx.

Differences in the top box scores by gender are small. There is also not an apparent difference in scores due to ethnicity.

Older patients generally reported more positive patient experiences. The group that gave the highest top box scores for global rating of surgeon were the youngest group of patients (18-24 years) and patients age 65-74 (93% and 89%, respectively). The scores from the older group is consistent with a study of Hospital CAHPS. In that study, O’Malley et al (2005) found that younger age patients (18-24) scored significantly lower than patients 25-34 and patients in the eight age categories above 34 all scored higher than those 25-34.

Citations:

O’Malley AJ, Zaslavsky AM, Elliott MN, Zaboriski L and Cleary PD (2005) Case-Mix Adjustment of the CAHPS[®] Hospital Survey. Health Services Research. Dec. Volume 40, Issue 6p2, pages 2162–2181.

[Response Ends]

1b.05. If no or limited data on disparities from the measure as specified is reported above, 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 above.

[Response Begins]

N/A

[Response Ends]

2. 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.

spma.01. Indicate whether there are changes to the specifications since the last updates/submission. If yes, update the specifications in the Measure Specifications section of the Measure Submission Form, and explain your reasoning for the changes below.

[Response Begins]

Yes

[Response Ends]

spma.02. Briefly describe any important changes to the measure specifications since the last measure update and provide a rationale.

For annual updates, please explain how the change in specifications affects the measure results. If a material change in specification is identified, data from re-testing of the measure with the new specifications is required for early maintenance review.

For example, specifications may have been updated based on suggestions from a previous NQF CDP review.

[Response Begins]

Recommendation to include E-mail as part of Mixed-mode Survey Administration

Based on field test results, the CAHPS team recommends the following modes:

- Mail only.
- Telephone only.
- Mixed mode (mail and telephone, email and mail, or email and telephone).

The addition of e-mail administration (i.e., notification for web-based surveys) as a type of mixed-mode data collection (Drake et al., 2014; McInnes et al., 2012) is a recommendation since last endorsement. The CAHPS Consortium recommends including an option to conduct a mixed mode survey that would have two e-mail reminders and a follow-up by mail or telephone to all who are surveyed. The follow-up to the entire sampling frame is necessary to get a representative sample from a practice that is not based just on e-mail alone. The Consortium does not recommend a mailed hard copy letter with a link to a web survey.

While there are no explicit data on the use of electronic capture for the CAHPS Surgical Care Survey, the psychometric properties of surveys does not appear to change when transition from paper to electronic data capture (Bennett AV, et al. 2014).

Citation:

Bennett AV, Keenoy K, Shouery M, Basch E, Temple LK. Evaluation of mode equivalence of the MSKCC Bowel Function Instrument, LASA Quality of Life, and Subjective Significance Questionnaire items administered by Web, interactive voice response system (IVRS), and paper. Qual Life Res. 2016; 25:1123-30.

Drake KM, Hargraves JL, Lloyd S, Gallagher PM, Cleary PD. The Effect of Response Scale, Administration Mode, and Format on Responses to the CAHPS Clinician and Group Survey. Health Serv Res. 2014 Aug;49(4):1387-99. doi: 10.1111/1475-6773.12160

McInnes DK, Brown JA, Hays RD, Gallagher P, Ralston JD, Hugh M, Kanter M, Serrato CA, Cosenza C, Halamka J,

Ding L, Cleary PD. (2012) Development and evaluation of CAHPS questions to assess the impact of health information technology on patient experiences with ambulatory care. Med Care. 2012 Nov;50 Suppl:S11-9.

[Response Ends]

sp.01. Provide the measure title.

Measure titles should be concise yet convey who and what is being measured (see [What Good Looks Like](#)).

[Response Begins]

Consumer Assessment of Healthcare Providers and Systems (CAHPS)[®] Surgical Care Survey Version 2.0

[Response Ends]

sp.02. Provide a brief description of the measure.

Including type of score, measure focus, target population, timeframe, (e.g., Percentage of adult patients aged 18-75 years receiving one or more HbA1c tests per year).

[Response Begins]

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Measure 7: Rating of surgeon (1 item)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surgical Care Survey (S-CAHPS) is a standardized survey instrument that asks patients about their experience before, during and after surgery received from providers and their staff in both inpatient and outpatient (or ambulatory) settings. S-CAHPS is administered to adult patients (age 18 and over) that had an operation as defined by CPT codes (90 day globals) within 3 to 6 months prior to the start of the survey.

The S-CAHPS expands on the CAHPS Clinician & Group Survey (CG-CAHPS), which focuses on primary and specialty medical care, by incorporating domains that are relevant to surgical care, such as sufficient communication to obtain informed consent, anesthesia care, and post-operative follow-up and care coordination. Other questions ask patients to report on their experiences with office staff during visits and to rate the surgeon.

The S-CAHPS survey is sponsored by the American College of Surgeons (ACS). The survey was approved as a CAHPS product in early 2010 and the Agency for Healthcare Research and Quality (AHRQ) released version 1.0 of the survey in the spring of 2010. The S-CAHPS survey Version 2.0 was subsequently endorsed by NQF in June 2012 (NQF #1741). The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at <https://cahps.ahrq.gov/surveys-guidance/cg/about/index.html>. Surgeons may customize the S-CAHPS survey by adding survey items that are specific to their patients and practice. However, the core survey must be used in its entirety in order to be comparable with other S-CAHPS data. The S-CAHPS survey is available in English and Spanish.

The 6 composite measures are made up of the following items:

The 1 single item measure (Measure 7) is (Q35): Using any number from 0 to 10, where 0 is the worst surgeon possible and 10 is the best surgeon possible, what number would you use to rate all your care from this surgeon?

Measure 1: Information to help you prepare for surgery (2 items)

Q3. Before your surgery, did anyone in this surgeon's office give you all the information you needed about your surgery?

Q4. Before your surgery, did anyone in this surgeon's office give you easy to understand instructions about getting ready for your surgery?

Measure 2: How well surgeon communicates with patients before surgery (4 items)

Q9. During your office visits before your surgery, did this surgeon listen carefully to you?

Q10. During your office visits before your surgery, did this surgeon spend enough time with you?

Q11. During your office visits before your surgery, did this surgeon encourage you to ask questions?

Q12. During your office visits before your surgery, did this surgeon show respect for what you had to say?

Measure 3: Surgeon's attentiveness on day of surgery (2 items)

Q15. After you arrived at the hospital or surgical facility, did this surgeon visit you before your surgery?

Q17. Before you left the hospital or surgical facility, did this surgeon discuss the outcome of your surgery with you?

Measure 4: Information to help you recover from surgery (4 items)

Q26. Did anyone in this surgeon's office explain what to expect during your recovery period?

Q27. Did anyone in this surgeon's office warn you about any signs or symptoms that would need immediate medical attention during your recovery period?

Q28. Did anyone in this surgeon's office give you easy to understand instructions about what to do during your recovery period?

Q29. Did this surgeon make sure you were physically comfortable or had enough pain relief after you left the hospital or surgical facility where you had your surgery?

Measure 5: How well surgeon communicates with patients after surgery (4 items)

Q31. After your surgery, did this surgeon listen carefully to you?

Q32. After your surgery, did this surgeon spend enough time with you?

Q33. After your surgery, did this surgeon encourage you to ask questions?

Q34. After your surgery, did this surgeon show respect for what you had to say?

Measure 6: Helpful, courteous, and respectful staff at surgeon's office (2 items)

Q36. During these visits, were clerks and receptionists at this surgeon's office as helpful as you thought they should be?

Q37. During these visits, did clerks and receptionists at this surgeon's office treat you with courtesy and respect?

[Response Ends]

sp.04. Check all the clinical condition/topic areas that apply to your measure, below.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- *Surgery: General*

[Response Begins]

Surgery

[Response Ends]

sp.05. Check all the non-condition specific measure domain areas that apply to your measure, below.

[Response Begins]

[Response Ends]

sp.06. Select one or more target population categories.

Select only those target populations which can be stratified in the reporting of the measure's result.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- *Populations at Risk: Populations at Risk*

[Response Begins]

Elderly (Age >= 65)

[Response Ends]

sp.07. Select the levels of analysis that apply to your measure.

Check ONLY the levels of analysis for which the measure is SPECIFIED and TESTED.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- *Clinician: Clinician*
- *Population: Population*

[Response Begins]

Clinician: Group/Practice

[Response Ends]

sp.08. Indicate the care settings that apply to your measure.

Check ONLY the settings for which the measure is SPECIFIED and TESTED.

[Response Begins]

Inpatient/Hospital

Other

Outpatient Services

[Response Ends]

sp.09. 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. If no URL is available, indicate "none available".

[Response Begins]

<https://www.ahrq.gov/cahps/surveys-guidance/surgical/index.html>

[Response Ends]

sp.12. Attach the data dictionary, code table, or value sets (and risk model codes and coefficients when applicable). Excel formats (.xlsx or .csv) are preferred.

Attach an excel or csv file; if this poses an issue, [contact staff](#). Provide descriptors for any codes. Use one file with multiple worksheets, if needed.

[Response Begins]

No data dictionary/code table – all information provided in the submission form

[Response Ends]

For the question below: state the outcome being measured. Calculation of the risk-adjusted outcome should be described in sp.22.

sp.13. State the numerator.

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.

[Response Begins]

We recommend that S-CAHPS Survey items and composites be calculated using a top-box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses.

The top box numerator for the Overall Rating of Surgeon is the number of respondents who answered 9 or 10 for the item, with 10 indicating “Best provider possible”.

For more information on the calculation of reporting measures, see What’s Available for the CAHPS Surgical Care Survey: <https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/surgical/about/whats-available-surgical-care-survey.pdf>

Also see Patient Experience Measures from the CAHPS Surgical Care Survey Document 409 obtained by going to: <https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html>

Also, for more information on the calculation of reporting measures, see How to Report Results of the CAHPS Clinician & Group Survey, available at <https://cahps.ahrq.gov/surveys-guidance/cg/cgkit/HowtoReportResultsofCGCAHPS080610FINAL.pdf>.

[Response Ends]

For the question below: describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in sp.22.

sp.14. Provide details needed to calculate the numerator.

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 sp.11.

[Response Begins]

This section is used to describe the composite top box score. The composite top box score is the average proportion of respondents who answered the most positive response category across the questions in the composite.

The top box numerators for items within Composite measures 1, 2, 4, 5, and 6 is the number of respondents who answered "Yes, definitely" across the items in each composite. The top box composite score is the average proportion of respondents who answered "Yes, definitely" across the items in the composite.

The top box numerator for items within Composite measure 3 is the number of respondents who answered "Yes" across the items in this composite. The top box composite score is the average proportion of respondents who answered "Yes" across the items in this composite.

The top box numerator for the Measure 7, the Global Rating Item, is the number of respondents who answered 9 or 10 to the Global Rating Item.

EXAMPLE:

Given a composite with four items, where each item has three response options, a practice's score for that composite is the proportion of responses (excluding missing data) in each response category.

The following steps show how those proportions are calculated:

Step 1 – Calculate the proportion of cases in each response category for the first question:

P11 = Proportion of respondents who answered "yes, definitely"

P12 = Proportion of respondents who answered "yes, somewhat"

P13 = Proportion of respondents who answered "no"

Follow the same steps for the second question:

P21 = Proportion of respondents who answered "yes, definitely"

P22 = Proportion of respondents who answered "yes, somewhat"

P23 = Proportion of respondents who answered "no"

Repeat the same procedure for each of the questions in the composite.

Step 2 – Combine responses from the questions to form the composite.

Calculate the average proportion responding to each category across the questions in the composite. For example, in the "How Well Surgeon Communicates With Patients Before Surgery" composite (four items), the calculations would be as follows:

Measure top box score = proportion who said "yes, definitely" = $(P11 + P21 + P31 + P41) / 4$

Example results: If P11 = 81% and P21=92% and P31 = 84% and P41 = 95% then the top box score = $(81\% + 92\% + 84\% + 95\%) / 4 = 88\%$.

Also see Patient Experience Measures from the CAHPS Surgical Care Survey Document 409 obtained by going to:
<https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html>

[Response Ends]

For the question below: state the target population for the outcome. Calculation of the risk-adjusted outcome should be described in sp.22.

sp.15. State the denominator.

Brief, narrative description of the target population being measured.

[Response Begins]

The measure's denominator is the number of survey respondents. The target population for the survey is adult patients (age 18 and over) who had a major surgery as defined by Common Procedural Terminology (CPT) codes (90 day globals) within 3 to 6 months prior to the start of the survey.

Results will typically be compiled over a 12-month period.

For more information on the calculation of reporting measures, see Patient Experience Measures from the CAHPS Surgical Care Survey, available at <https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html>.

[Response Ends]

For the question below: describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in sp.22.

sp.16. Provide details needed to calculate the denominator.

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 sp.11.

[Response Begins]

For each item in a composite and the provider rating item, the top box denominator is the number of respondents who answered the item per aggregate-level entity (e.g., a surgeon or practice site). For each composite score, the denominator is the number of respondents who answer at least one item within the composite. Composite scores are the average proportion of respondents who gave the highest rating across the items in the composite (as discussed in S.5).

The survey is sampled at the ambulatory care level. However, there are questions that ask about care received at the hospital or surgical care facility.

The major criterion for selecting patients is having surgery, as defined by Medicare 90-day global surgery codes within 3 to 6 months prior to the start of the survey. Since post-surgical care was an important component of the survey, surveys could not be appropriately administered until an adequate time for experiencing post-surgical care (3 months) had passed. The time frame for the surgery was selected to (1) minimize recall bias and (2) ensure ample time was allowed for follow-up care after surgery. The survey is not administered more than 6 months post-surgery because of concerns about recall bias.

Patients have to be adults and non-institutionalized. Included surgeries should be scheduled and not an emergency procedure. This is because an important component of the survey deals with pre-surgical office visits – a topic which would not be relevant for most emergency surgeries.

The Survey's denominator code table lists 90-day global CPT codes for major surgery, representing over 10,000 possible codes across multiple surgical specialties. The Surgical Quality Alliance felt that specifying only Medicare's 90-day global procedure codes would include appropriate procedures while excluding minor procedures that were not intended to be included.

The attached excel file named "Attachment A Main S7 CY2015-90-day-global codes.xlsx" includes the CPT codes that are currently used to identify the S-CAHPS survey's target population of patient with major surgery (i.e., measure denominator).

[Response Ends]

sp.17. Describe the denominator exclusions.

Brief narrative description of exclusions from the target population.

[Response Begins]

The following are excluded when constructing the sampling frame:

- Surgical patients whose procedure was greater than 6 months or less than 3 months prior to the start of the survey.
- Surgical patients younger than 18 years old.
- Surgical patients who are institutionalized (put in the care of a specialized institution) or deceased.

[Response Ends]

sp.18. Provide details needed to calculate the denominator exclusions.

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 sp.11.

[Response Begins]

The following patients would be excluded from the measure's denominator:

- Survey users and vendors should exclude surveys where the respondent reports he or she has not had surgery performed on the date listed by the surgeon named. (First question of survey.)
- Surgical patients that had an emergency surgical procedure since emergency procedures are unlikely to have visits with the surgeon before the surgery.
- Individuals from a household that has already been sampled.
- Respondents who did NOT answer at least one item of the measure are NOT included in the denominator.

Instructions on how to transform raw data from a CAHPS survey into data that the CAHPS Analysis Program can use can be found in Preparing and Analyzing Data from the CAHPS Clinician & Group Surveys available at https://www.cahps.ahrq.gov/surveys-guidance/survey4.0-docs/1035_Preparing_analyzing_data_from_cg.pdf

Survey code specifications --- including how to code an appropriately skipped item, multiple marks or blank items -- can be found in the Instructions for Analyzing Data available at <https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2015-Instructions-for-Analyzing-Data-from-CAHPS-Surveys.pdf>.

[Response Ends]

sp.19. Provide all information required to stratify the measure results, if necessary.

Include 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 in the Data Dictionary field.

[Response Begins]

If survey users want to combine data for reporting from different sampling strata, they will need to create a text file that identifies the strata and indicates which ones are being combined and the identifier of the entity obtained by combining them.

See pages 18-19 of the Instructions for Analyzing Data available at <https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2015-Instructions-for-Analyzing-Data-from-CAHPS-Surveys.pdf>.

[Response Ends]

sp.20. Is this measure adjusted for socioeconomic status (SES)?

[Response Begins]

[Response Ends]

sp.21. Select the risk adjustment type.

Select type. Provide specifications for risk stratification and/or risk models in the Scientific Acceptability section.

[Response Begins]

[Response Ends]

sp.22. Select the most relevant type of score.

Attachment: If available, please provide a sample report.

[Response Begins]

[Response Ends]

sp.23. Select the appropriate interpretation of the measure score.

Classifies interpretation of score according to whether better quality or resource use is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score

[Response Begins]

Better quality = Higher score

[Response Ends]

sp.24. Diagram or describe the calculation of the measure score as an ordered sequence of steps.

Identify the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period of data, aggregating data; risk adjustment; etc.

[Response Begins]

Top Box Score Calculation:

- 1) Target Population: Patients that had a non-emergency surgery within 3 to 6 months prior to the start of the survey.
 - 2) Exclusions = Patients who did not answer at least one item of the composite measures or rating item.
 - 3) Screener items. Example: Patients who answered “No” to the first item indicating that the patient had surgery performed on the date listed by the surgeon named.
 - 4) Top-box scores (percent with highest rating) are computed for each item
 - 5) Top-box scores are averaged across the items within each composite, weighting each item equally.
- Note that for users who want to case-mix adjust their scores, case-mix adjustment can be done using the CAHPS macro and the adjustment is made prior to the calculation of the total score.

Case-mix Adjusted Scores

Case-mix adjustment is done via linear regression. The CAHPS Consortium recommends self-reported overall health, age, and education as adjusters. These items are printed in the "About You" section of the survey, questions 38-45.

The steps for user-defined calculations of risk-adjusted scores can be found in Instructions for Analyzing Data from CAHPS[®] Surveys: Using the CAHPS Analysis Program Version 4.1 available at <https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2015-Instructions-for-Analyzing-Data-from-CAHPS-Surveys.pdf>.

[Response Ends]

sp.25. Attach a copy of the instrument (e.g. survey, tool, questionnaire, scale) used as a data source for your measure, if available.

[Response Begins]

[Response Ends]

sp.26. Indicate the responder for your instrument.

[Response Begins]

Patient

[Response Ends]

sp.27. If measure testing is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.

Examples of samples used for testing:

- Testing may be conducted on a sample of the accountable entities (e.g., hospital, physician). The analytic unit specified for the particular measure (e.g., physician, hospital, home health agency) determines the sampling strategy for scientific acceptability testing.

- *The sample should represent the variety of entities whose performance will be measured. The [2010 Measure Testing Task Force](#) recognized that the samples used for reliability and validity testing often have limited generalizability because measured entities volunteer to participate. Ideally, however, all types of entities whose performance will be measured should be included in reliability and validity testing.*
- *The sample should include adequate numbers of units of measurement and adequate numbers of patients to answer the specific reliability or validity question with the chosen statistical method.*
- *When possible, units of measurement and patients within units should be randomly selected.*

[Response Begins]

The following sampling guidelines are provided to users as part of the “Fielding the CAHPS[®] Clinician & Group Surveys: Sampling Guidelines and Protocols” document available at https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/1033_CG_Fielding_the_Survey.pdf.

Defining the Sample Frame: Eligibility Guidelines

The sample will be drawn from a list of individuals (adults age 18 and older) who had a planned surgery from the surgeon during the specified time interval (see below). The list is called a sample frame.

The source of sample information will vary by survey sponsor. The decision will depend on which organization has the most accurate and complete data. Health plans or purchasers of care may have administrative or billing data to identify individual patients. In some instances, the data to identify individual patients may be found only in the records of medical practices. It may be necessary to pull data from two or more sources in order to have both up-to-date contact information and to be able to connect the procedure to a specific surgeon.

Users should review these guidelines for determining who to include in the sample frame:

- Include only adult patients (age 18 and over) that had a major surgery as defined by CPT codes (90 day globals) within the last 3 to 6 months. This time frame is also known as the look back period.
- The sampling frame is a person-level list and not a procedure list. Therefore, patients should appear only once in the sampling frame regardless of how many surgeries they have had in the look back period. Use the patient’s most recent surgery for inclusion in the sampling frame.
- Draw the sample irrespective of reason for surgery and duration of patient-provider relationship, so that the full range of patients is represented.
- Include all patients who meet the sampling criteria even if they are no longer receiving care from the practice.
- To identify the sampling frame, use the anticipated start date of data collection to determine the reference period. For example, if your anticipated start date is September 1, 2011, include all those who have had surgery during February 1 – May 31.
- Allow the sample frame to include multiple individuals from the same household, but the sample you draw should not have more than one adult per household. In other words, the sample that is selected for data collection should be de-duplicated to ensure that only one person per household receives a survey.
- All CAHPS survey items have been designed for the general population. Appropriate screening items are included for items targeted to assess a specific experience. In order to ensure that results are comparable to those produced by other sponsors and vendors, targeted sampling, such as selecting only patients with particular conditions or experiences, is not recommended. Targeted sampling should only be used to supplement the general population sample, if desired.
- To administer the survey, the name of the surgeon must be available, even if you are surveying at the practice level. If the sampling frame does not accurately identify the surgeon who performed the surgery, you may want to select a larger sample to account for errors in connecting health care received to a specific provider.

Recommended Number of Completes

In order to determine the size of the sample, you first need to determine the level of sampling and how many completed surveys are required to obtain usable information at that level. The CAHPS Clinician & Group Survey

and the CAHPS Surgical Care Survey can be used to assess care at the individual provider, practice site/clinic, or medical group level. A practice site/clinic is based on a single geographic location. A medical group may contain multiple practice sites/clinics and is defined by a specific list of providers.

- Individual providers: 45 completed surveys per provider. For applications of the survey intended to report or assess performance for individual providers, the Consortium recommends at least 45 completed surveys per provider.

- Practice site: The recommended number of completed surveys is based on the number of surgeons at the site. The site-level sample size recommendations vary by the number of surgeons per location site. The CAHPS Consortium has issued the following recommended sample sizes for collecting CAHPS Clinician and Group (CG-CAHPS) data at the practice site level: 50 completed surveys for 1 provider at the site, 100 surveys for 2 providers at the site, 150 for 3 providers, 175 for 4 to 9 providers, 200 for 10-13 providers, and 250 for 14-19 providers at the site. These recommendations are set to achieve between .70 and .80 site-level reliability for all composite measures. Sample size requirements increase with the number of providers practicing at the site.

The minimum sample size recommendations are based on extensive research conducted on the CAHPS Clinician & Group Survey. These recommendations are based on data regarding the number of completed questionnaires necessary to achieve adequate physician-level reliability for a measure. That is, how many completed surveys does one need to reliably distinguish among different physicians? To answer this question, CAHPS investigators examined data from multiple field trials.

Sample Size Calculation: To have a sufficient number of responses for analysis and reporting, survey users need to select enough individuals to obtain approximately 45 completed questionnaires per physician. Assuming you achieve the recommended response rate of 40 percent, survey users would need to start with a minimum sample size of 113.

More detail and reasoning behind the recommendations can be found in the 2011 document titled “Fielding the CAHPS[®] Clinician & Group Surveys: Sampling Guidelines and Protocols” available at https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/1033_CG_Fielding_the_Survey.pdf.

Citation:

Dyer, N., J. S. Sorra, et al. (2012). "Psychometric properties of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Adult Visit Survey." Medical care 50 Suppl: S28-34.

[Response Ends]

sp.28. Identify whether and how proxy responses are allowed.

[Response Begins]

[Response Ends]

sp.29. Survey/Patient-reported data.

Provide instructions for data collection and guidance on minimum response rate. Specify calculation of response rates to be reported with performance measure results.

[Response Begins]

The measures are dependent on the standardized implementation of the complete CAHPS Surgical Care Survey. Failure to administer the entire survey will compromise the validity and reliability of the measures.

Developing the Sampling Frame

The sampling frame for the CAHPS Surgical Care Survey consists of patients that have had a non-emergency 90-day global procedure in the last 3-6 months from the date that the survey will be administered. The sampling frame is a

patient level file – patients with multiple procedures that meet the criteria may not be included multiple times in the sampling. The actual sample will be de-duplicated to ensure that patients are not provided more than one survey. Users of S-CAHPS should follow the recommended guidelines of the CAHPS Clinician and Group Survey found in the “Fielding the CAHPS[®] Clinician & Group Surveys: Sampling Guidelines and Protocols” document available at https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/1033_CG_Fielding_the_Survey.pdf.

Preparing Sample Files for Data Collection

Once the sample has been selected, the vendor assigns a unique identification (ID) number to each sampled person. This unique ID number should not be based on an existing identifier such as a Social Security number or a patient ID number. This number will be used only to track the respondents during data collection.

As previously noted, some sample frames may not include complete and accurate contact information, requiring the combination of information from two (or more) sources – such as administrative records from the plan and contact records from the medical group or clinician office. When information from two sources differs, sponsors and their survey vendors should consult with each other to decide which sources of information are most accurate and should be used. This may be a complex, multistep process that requires time and rigorous quality control. In addition, because the sponsor may be responsible for some elements of this process and the vendor for others, it is important to carefully coordinate this process. The pieces of information that are most critical to the success of data collection are accurate and complete patient [parent/guardian] and provider names and contact information appropriate for the mode of administration (i.e., addresses for mail surveys, telephone number for telephone administration, and e-mail addresses for web-based administration). When you have incomplete address information or reason to believe that this information may be inaccurate, sponsors and/or vendors may be able to use other sources, such as CD-ROM directories, Internet sources, or directory assistance, to clean the sample file.

Data Collection Modes

Each survey sponsor will need to choose the data collection mode that maximizes the response rate at an acceptable cost.

Based on field test results, the CAHPS team recommends the following modes:

- Mail only.
- Telephone only.
- Mixed mode (mail and telephone, email and mail, or email and telephone).

Survey sponsors that employ one of these modes using the recommended protocols can expect to achieve response rates of approximately 40 percent or higher.

Results from the field tests, as well as the experiences of organizations that have fielded similar surveys, indicate that the mail with telephone followup method is most effective; results from survey research literature indicate that followup by telephone often adds 10 to 15 percentage points to the response rate. A sample telephone script for Surgical CAHPS in both English and Spanish is available at https://www.cahps.ahrq.gov/surveys-guidance/survey4.0-docs/sample_tele_script_surgical_care_survey.pdf.

Note that the addition of e-mail administration (i.e., notification for web-based surveys) as a type of mixed-mode data collection is a recommendation since last endorsement. The CAHPS Consortium recommends including an option to conduct a mixed mode survey that would have two e-mail reminders and a follow up by mail or telephone to all who are surveyed. The follow up to the entire sampling frame is necessary to get a representative sample from a practice that is not based just on e-mail alone. The Consortium does not recommend a mailed hard copy letter with a link to a web survey.

Other Modes

The CAHPS team recognizes that many organizations may already be or are interested in conducting patient surveys using different modes of survey administration and has conducted preliminary testing of other modes, specifically in-office distribution and interactive voice response (IVR, also known as telephone audio computer-

assisted self-interviewing, or T-ACASI). Further study is required before either of these modes can be recommended.

A study of in-office distribution found that the survey results were not comparable to those collected with recommended modes. The investigators observed incomplete distribution rates, lower response rates, and declining distribution rates. Finally, there were significant mode-physician interaction effects, which suggests that data cannot be pooled then adjusted to account for the differences. Because the implications of using these modes are not yet fully known, they should be used with caution. If a sponsor uses one of these modes to collect data, the ability to compare survey results across sponsors may be limited.

The Consortium's support of the use of multiple modes of survey administration is intended to minimize disruption to organization's current survey processes. Thus, organizations that conduct mail surveys can continue using mail, those that conduct telephone surveys can continue using telephone, and likewise for other modes. More detail on the protocols per mode, can be found in the full fielding guide. The Consortium is currently collecting and analyzing data in order to assess the need for procedures for data adjustments as a function of each survey mode and to enable the team to develop such procedures.

Tracking Returned Questionnaires

Most vendors have established methods for tracking the sample. You should also set up a system to track the returned surveys by the unique ID number that is assigned to each respondent in the sample. This ID number should be placed on every questionnaire that is mailed and/or on the call record of each telephone case.

To maintain respondent confidentiality, the tracking system should not contain any of the survey responses. The survey responses should be entered in a separate data file linked to the sample file by the unique ID number. (This system will generate the weekly progress reports that sponsors and vendors should review closely.)

Each respondent in the tracking system should be assigned a survey result code that indicates whether the respondent completed and returned the questionnaire, completed the telephone interview, was ineligible to participate in the study, could not be located, is deceased, or refused to respond. The tracking system should also include the date the survey was returned or the telephone interview completed. The interim result code reflects the status of the case during the different rounds of data collection, and the final result code reflects the status at the end of data collection. These result codes are used to calculate response rates.

Citation:

Drake KM, Hargraves JL, Lloyd S, Gallagher PM, Cleary PD. The Effect of Response Scale, Administration Mode, and Format on Responses to the CAHPS Clinician and Group Survey. *Health Serv Res.* 2014 Aug;49(4):1387-99. doi: 10.1111/1475-6773.12160

McInnes DK, Brown JA, Hays RD, Gallagher P, Ralston JD, Hugh M, Kanter M, Serrato CA, Cosenza C, Halamka J, Ding L, Cleary PD. (2012) Development and evaluation of CAHPS questions to assess the impact of health information technology on patient experiences with ambulatory care. *Med Care.* 2012 Nov;50 Suppl:S11-9.

[Response Ends]

sp.30. Select only the data sources for which the measure is specified.

[Response Begins]

Instrument-Based Data

[Response Ends]

sp.31. Identify the specific data source or data collection instrument.

For example, provide the name of the database, clinical registry, collection instrument, etc., and describe how data are collected.

[Response Begins]

Consumer Assessment of Health Providers and Systems (CAHPS) Surgical Care Survey Version 2.0

Available in English at https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/surgical_eng.pdf

Available in Spanish at https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/surgical_span.pdf

[Response Ends]

sp.32. Provide the data collection instrument.

[Response Begins]

[Response Ends]

2ma.01. Indicate whether additional empirical reliability testing at the accountable entity level has been conducted. If yes, please provide results in the following section, Scientific Acceptability: Reliability - Testing. Include information on all testing conducted (prior testing as well as any new testing).

Please separate added or updated information from the most recent measure evaluation within each question response in the Scientific Acceptability sections. For example:

Current Submission:

Updated testing information here.

Previous Submission:

Testing from the previous submission here.

[Response Begins]

No

[Response Ends]

2ma.02. Indicate whether additional empirical validity testing at the accountable entity level has been conducted. If yes, please provide results in the following section, Scientific Acceptability: Validity - Testing. Include information on all testing conducted (prior testing as well as any new testing).

Please separate added or updated information from the most recent measure evaluation within each question response in the Scientific Acceptability sections. For example:

Current Submission:

Updated testing information here.

Previous Submission:

Testing from the previous submission here.

[Response Begins]

No

[Response Ends]

2ma.03. For outcome, patient-reported outcome, resource use, cost, and some process measures, risk adjustment/stratification may be conducted. Did you perform a risk adjustment or stratification analysis?

[Response Begins]

[Response Ends]

2ma.04. For maintenance measures in which risk adjustment/stratification has been performed, indicate whether additional risk adjustment testing has been conducted since the most recent maintenance evaluation. This may include updates to the risk adjustment analysis with additional clinical, demographic, and social risk factors.

Please update the Scientific Acceptability: Validity - Other Threats to Validity section.

Note: This section must be updated even if social risk factors are not included in the risk adjustment strategy.

[Response Begins]

[Response Ends]

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate fields in the Scientific Acceptability sections of the Measure Submission Form.

- Measures must be tested for all the data sources and levels of analyses that are specified. If there is more than one set of data specifications or more than one level of analysis, contact NQF staff about how to present all the testing information in one form.
- All required sections must be completed.
- For composites with outcome and resource use measures, Questions 2b.23-2b.37 (Risk Adjustment) also must be completed.
- If specified for multiple data sources/sets of specifications (e.g., claims and EHRs), Questions 2b.11-2b.13 also must be completed.
- An appendix for supplemental materials may be submitted (see Question 1 in the Additional section), but there is no guarantee it will be reviewed.
- Contact NQF staff with any questions. Check for resources at the [Submitting Standards webpage](#).
- For information on the most updated guidance on how to address social risk factors variables and testing in this form refer to the release notes for the [2021 Measure Evaluation Criteria and Guidance](#).

Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the testing results for this measure meet NQF's evaluation criteria for testing.

2a. Reliability testing demonstrates the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or that the measure score is precise. For instrument-based measures (including PRO-PMs) and composite performance measures, reliability should be demonstrated for the computed performance score.

2b1. Validity testing demonstrates that the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality. For instrument based measures

(including PRO-PMs) and composite performance measures, validity should be demonstrated for the computed performance score.

2b2. Exclusions are supported by the clinical evidence and are of sufficient frequency to warrant inclusion in the specifications of the measure;

AND

If patient preference (e.g., informed decision-making) is a basis for exclusion, there must be evidence that the exclusion impacts performance on the measure; in such cases, the measure must be specified so that the information about patient preference and the effect on the measure is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately).

2b3. For outcome measures and other measures when indicated (e.g., resource use):

- an evidence-based risk-adjustment strategy (e.g., risk models, risk stratification) is specified; is based on patient factors (including clinical and social risk factors) that influence the measured outcome and are present at start of care; 14,15 and has demonstrated adequate discrimination and calibration

OR

- rationale/data support no risk adjustment/ stratification.

2b4. Data analysis of computed measure scores demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful 16 differences in performance;

OR

there is evidence of overall less-than-optimal performance.

2b5. If multiple data sources/methods are specified, there is demonstration they produce comparable results.

2b6. Analyses identify the extent and distribution of missing data (or nonresponse) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and non-responders) and how the specified handling of missing data minimizes bias.

2c. For composite performance measures, empirical analyses support the composite construction approach and demonstrate that:

2c1. the component measures fit the quality construct and add value to the overall composite while achieving the related objective of parsimony to the extent possible; and

2c2. the aggregation and weighting rules are consistent with the quality construct and rationale while achieving the related objective of simplicity to the extent possible.

(if not conducted or results not adequate, justification must be submitted and accepted)

Definitions

Reliability testing applies to both the data elements and computed measure score. Examples of reliability testing for data elements include, but are not limited to: inter-rater/abstractor or intra-rater/abstractor studies; internal consistency for multi-item scales; test-retest for survey items. Reliability testing of the measure score addresses precision of measurement (e.g., signal-to-noise).

Validity testing applies to both the data elements and computed measure score. Validity testing of data elements typically analyzes agreement with another authoritative source of the same information. Examples of validity testing of the measure score include, but are not limited to: testing hypotheses that the measures scores indicate quality of care, e.g., measure scores are different for groups known to have differences in quality assessed by another valid quality measure or method; correlation of measure scores with another valid indicator of quality for the specific topic; or relationship to conceptually related measures (e.g., scores on process measures to scores on outcome measures). Face validity of the measure score as a quality indicator may be adequate if accomplished through a systematic and transparent process, by identified experts, and explicitly addresses whether performance

scores resulting from the measure as specified can be used to distinguish good from poor quality. The degree of consensus and any areas of disagreement must be provided/discussed.

Examples of evidence that an exclusion distorts measure results include, but are not limited to: frequency of occurrence, variability of exclusions across providers, and sensitivity analyses with and without the exclusion.

Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.

Risk factors that influence outcomes should not be specified as exclusions.

With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74 percent v. 75 percent) is clinically meaningful; or whether a statistically significant difference of \$25 in cost for an episode of care (e.g., \$5,000 v. \$5,025) is practically meaningful. Measures with overall less-than-optimal performance may not demonstrate much variability across providers.

Please separate added or updated information from the most recent measure evaluation within each question response in the Scientific Acceptability sections. For example:

Current Submission:

Updated testing information here.

Previous (Year) Submission:

Testing from the previous submission here.

2a.01. Select only the data sources for which the measure is tested.

[Response Begins]

[Response Ends]

2a.02. If an existing dataset was used, identify the specific dataset.

The dataset used for testing must be consistent with the measure specifications for target population and healthcare entities being measured; e.g., Medicare Part A claims, Medicaid claims, other commercial insurance, nursing home MDS, home health OASIS, clinical registry).

[Response Begins]

[Response Ends]

2a.03. Provide the dates of the data used in testing.

Use the following format: "MM-DD-YYYY - MM-DD-YYYY"

[Response Begins]

[Response Ends]

2a.04. Select the levels of analysis for which the measure is tested.

Testing must be provided for all the levels specified and intended for measure implementation, e.g., individual clinician, hospital, health plan.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- *Clinician: Clinician*
- *Population: Population*

[Response Begins]

[Response Ends]

2a.05. List the measured entities included in the testing and analysis (by level of analysis and data source).

Identify the number and descriptive characteristics of measured entities included in the analysis (e.g., size, location, type); if a sample was used, describe how entities were selected for inclusion in the sample.

[Response Begins]

[Response Ends]

2a.06. Identify the number and descriptive characteristics of patients included in the analysis (e.g., age, sex, race, diagnosis), separated by level of analysis and data source; if a sample was used, describe how patients were selected for inclusion in the sample.

If there is a minimum case count used for testing, that minimum must be reflected in the specifications.

[Response Begins]

[Response Ends]

2a.07. If there are differences in the data or sample used for different aspects of testing (e.g., reliability, validity, exclusions, risk adjustment), identify how the data or sample are different for each aspect of testing.

[Response Begins]

[Response Ends]

2a.08. List the social risk factors that were available and analyzed.

For example, patient-reported data (e.g., income, education, language), proxy variables when social risk data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate) which do not have to be a proxy for patient-level data.

[Response Begins]

[Response Ends]

Note: If accuracy/correctness (validity) of data elements was empirically tested, separate reliability testing of data elements is not required – in 2a.09 check patient or encounter-level data; in 2a.010 enter “see validity testing section of data elements”; and enter “N/A” for 2a.11 and 2a.12.

2a.09. Select the level of reliability testing conducted.

Choose one or both levels.

[Response Begins]

[Response Ends]

2a.10. For each level of reliability testing checked above, describe the method of reliability testing and what it tests.

Describe the steps—do not just name a method; what type of error does it test; what statistical analysis was used.

[Response Begins]

[Response Ends]

2a.11. For each level of reliability testing checked above, what were the statistical results from reliability testing?

For example, provide the percent agreement and kappa for the critical data elements, or distribution of reliability statistics from a signal-to-noise analysis. For score-level reliability testing, when using a signal-to-noise analysis, more than just one overall statistic should be reported (i.e., to demonstrate variation in reliability across providers). If a particular method yields only one statistic, this should be explained. In addition, reporting of results stratified by sample size is preferred (pg. 18, [NQF Measure Evaluation Criteria](#)).

[Response Begins]

[Response Ends]

2a.12. Interpret the results, in terms of how they demonstrate reliability.

(In other words, what do the results mean and what are the norms for the test conducted?)

[Response Begins]

[Response Ends]

2b.01. Select the level of validity testing that was conducted.

[Response Begins]

[Response Ends]

2b.02. For each level of testing checked above, describe the method of validity testing and what it tests.

Describe the steps—do not just name a method; what was tested, e.g., accuracy of data elements compared to authoritative source, relationship to another measure as expected; what statistical analysis was used.

[Response Begins]

[Response Ends]

2b.03. Provide the statistical results from validity testing.

Examples may include correlations or t-test results.

[Response Begins]

[Response Ends]

2b.04. Provide your interpretation of the results in terms of demonstrating validity. (i.e., what do the results mean and what are the norms for the test conducted?)

[Response Begins]

[Response Ends]

2b.05. Describe the method for determining if statistically significant and clinically/practically meaningful differences in performance measure scores among the measured entities can be identified.

Describe the steps—do not just name a method; what statistical analysis was used? Do not just repeat the information provided in Importance to Measure and Report: Gap in Care/Disparities.

[Response Begins]

[Response Ends]

2b.06. Describe the statistical results from testing the ability to identify statistically significant and/or clinically/practically meaningful differences in performance measure scores across measured entities.

Examples may include number and percentage of entities with scores that were statistically significantly different from mean or some benchmark, different from expected; how was meaningful difference defined.

[Response Begins]

[Response Ends]

2b.07. Provide your interpretation of the results in terms of demonstrating the ability to identify statistically significant and/or clinically/practically meaningful differences in performance across measured entities.

In other words, what do the results mean in terms of statistical and meaningful differences?

[Response Begins]

[Response Ends]

2b.08. Describe the method of testing conducted to identify the extent and distribution of missing data (or non-response) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and non-responders). Include how the specified handling of missing data minimizes bias.

Describe the steps—do not just name a method; what statistical analysis was used.

[Response Begins]

[Response Ends]

2b.09. Provide the overall frequency of missing data, the distribution of missing data across providers, and the results from testing related to missing data.

For example, provide results of sensitivity analysis of the effect of various rules for missing data/non-response. If no empirical sensitivity analysis was conducted, identify the approaches for handling missing data that were considered and benefits and drawbacks of each).

[Response Begins]

[Response Ends]

2b.10. Provide your interpretation of the results, in terms of demonstrating that performance results are not biased due to systematic missing data (or differences between responders and non-responders), and how the specified handling of missing data minimizes bias.

In other words, what do the results mean in terms of supporting the selected approach for missing data and what are the norms for the test conducted; if no empirical analysis was conducted, justify the selected approach for missing data.

[Response Begins]

[Response Ends]

Note: This item is directed to measures that are risk-adjusted (with or without social risk factors) OR to measures with more than one set of specifications/instructions (e.g., one set of specifications for how to identify and compute the measure from medical record abstraction and a different set of specifications for claims or eQMs). It does not apply to measures that use more than one source of data in one set of specifications/instructions (e.g., claims data to identify the denominator and medical record abstraction for the numerator). Comparability is not required when comparing performance scores with and without social risk factors in the risk adjustment model. However, if comparability is not demonstrated for measures with more than one set of specifications/instructions, the different specifications (e.g., for medical records vs. claims) should be submitted as separate measures.

2b.11. Indicate whether there is more than one set of specifications for this measure.

[Response Begins]

[Response Ends]

2b.12. Describe the method of testing conducted to compare performance scores for the same entities across the different data sources/specifications.

Describe the steps—do not just name a method. Indicate what statistical analysis was used.

[Response Begins]

[Response Ends]

2b.13. Provide the statistical results from testing comparability of performance scores for the same entities when using different data sources/specifications.

Examples may include correlation, and/or rank order.

[Response Begins]

[Response Ends]

2b.14. Provide your interpretation of the results in terms of the differences in performance measure scores for the same entities across the different data sources/specifications.

In other words, what do the results mean and what are the norms for the test conducted.

[Response Begins]

[Response Ends]

2b.15. Indicate whether the measure uses exclusions.

[Response Begins]

[Response Ends]

2b.16. Describe the method of testing exclusions and what was tested.

Describe the steps—do not just name a method; what was tested, e.g., whether exclusions affect overall performance scores; what statistical analysis was used?

[Response Begins]

[Response Ends]

2b.17. Provide the statistical results from testing exclusions.

Include overall number and percentage of individuals excluded, frequency distribution of exclusions across measured entities, and impact on performance measure scores.

[Response Begins]

[Response Ends]

2b.18. Provide your interpretation of the results, in terms of demonstrating that exclusions are needed to prevent unfair distortion of performance results.

In other words, the value outweighs the burden of increased data collection and analysis. Note: If patient preference is an exclusion, the measure must be specified so that the effect on the performance score is transparent, e.g., scores with and without exclusion.

[Response Begins]

[Response Ends]

2b.19. Check all methods used to address risk factors.

[Response Begins]

[Response Ends]

2b.20. If using statistical risk models, provide detailed risk model specifications, including the risk model method, risk factors, risk factor data sources, coefficients, equations, codes with descriptors, and definitions.

[Response Begins]

[Response Ends]

2b.21. If an outcome or resource use measure is not risk-adjusted or stratified, provide rationale and analyses to demonstrate that controlling for differences in patient characteristics (i.e., case mix) is not needed to achieve fair comparisons across measured entities.

[Response Begins]

[Response Ends]

2b.22. Select all applicable resources and methods used to develop the conceptual model of how social risk impacts this outcome.

[Response Begins]

[Response Ends]

2b.23. Describe the conceptual and statistical methods and criteria used to test and select patient-level risk factors (e.g., clinical factors, social risk factors) used in the statistical risk model or for stratification by risk.

Please be sure to address the following: potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$ or other statistical tests; correlation of x or higher. Patient factors should be present at the start of care, if applicable. Also discuss any "ordering" of risk factor inclusion; note whether social risk factors are added after all clinical factors. Discuss any considerations regarding data sources (e.g., availability, specificity).

[Response Begins]

[Response Ends]

2b.24. Detail the statistical results of the analyses used to test and select risk factors for inclusion in or exclusion from the risk model/stratification.

[Response Begins]

[Response Ends]

2b.25. Describe the analyses and interpretation resulting in the decision to select or not select social risk factors.

Examples may include prevalence of the factor across measured entities, availability of the data source, empirical association with the outcome, contribution of unique variation in the outcome, or assessment of between-unit effects and within-unit effects. Also describe the impact of adjusting for risk (or making no adjustment) on providers at high or low extremes of risk.

[Response Begins]

[Response Ends]

2b.26. Describe the method of testing/analysis used to develop and validate the adequacy of the statistical model or stratification approach (describe the steps—do not just name a method; what statistical analysis was

used). Provide the statistical results from testing the approach to control for differences in patient characteristics (i.e., case mix) below. If stratified ONLY, enter "N/A" for questions about the statistical risk model discrimination and calibration statistics.

Validation testing should be conducted in a data set that is separate from the one used to develop the model.

[Response Begins]

[Response Ends]

2b.27. Provide risk model discrimination statistics.

For example, provide c-statistics or R-squared values.

[Response Begins]

[Response Ends]

2b.28. Provide the statistical risk model calibration statistics (e.g., Hosmer-Lemeshow statistic).

[Response Begins]

[Response Ends]

2b.29. Provide the risk decile plots or calibration curves used in calibrating the statistical risk model.

The preferred file format is .png, but most image formats are acceptable.

[Response Begins]

[Response Ends]

2b.30. Provide the results of the risk stratification analysis.

[Response Begins]

[Response Ends]

2b.31. Provide your interpretation of the results, in terms of demonstrating adequacy of controlling for differences in patient characteristics (i.e., case mix).

In other words, what do the results mean and what are the norms for the test conducted?

[Response Begins]

[Response Ends]

2b.32. Describe any additional testing conducted to justify the risk adjustment approach used in specifying the measure.

Not required but would provide additional support of adequacy of the risk model, e.g., testing of risk model in another data set; sensitivity analysis for missing data; other methods that were assessed.

[Response Begins]

[Response Ends]

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.

3.01. Check all methods below that are used to generate the data elements needed to compute the measure score.

[Response Begins]

[Response Ends]

3.02. Detail to what extent the specified data elements are available electronically in defined fields.

In other words, indicate whether data elements that are needed to compute the performance measure score are in defined, computer-readable fields.

[Response Begins]

No data elements are in defined fields in electronic sources

[Response Ends]

3.03. 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 data elements not from electronic sources.

[Response Begins]

Though multiple modes of data collection, as well as mixed mode types of administration, are possible and have been tested, CAHPS surveys are primarily delivered via mail. Electronic databases are created after mailed surveys are returned. Traditionally, the rationale for not using electronic sources more broadly is that mail and telephone are the best ways to obtain representative samples of patients based on the contact information that is available for sampling and data collection. However, email has been added as a mixed mode strategy for surgeon groups with reliable email addresses for all of their population. This is important as the uptake of electronic devices continues to grow.

[Response Ends]

3.04. Describe any efforts to develop an eCQM.

[Response Begins]

[Response Ends]

3.06. 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.

[Response Begins]

[Response Ends]

Consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

3.07. Detail 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),

Attach the fee schedule here, if applicable.

[Response Begins]

The CAHPS Surgical Care Survey is available to users free of charge. In addition to the survey instrument, users can access comprehensive fielding, analysis, and reporting guides as well as SAS programming code that performs analysis and significance testing. All of these tools are available at: <https://www.cahps.ahrq.gov/surveys-guidance/cg/instructions/index.html>. Requirements for using the CAHPS name on an instrument, include:

- All core items must be present on the user's questionnaire
- No changes to core item wording are permitted
- Instruments must not omit any of the survey items related to respondent characteristics.

[Response Ends]

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.

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making.

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 demonstrating performance improvement.

4a.01. Check all current uses. For each current use checked, please provide:

Name of program and sponsor

URL

Purpose

Geographic area and number and percentage of accountable entities and patients included

Level of measurement and setting

[Response Begins]

Public Reporting

Payment Program

Professional Certification or Recognition Program

Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

Quality Improvement (Internal to the specific organization)

Not in use

[Response Ends]

4a.02. Check all planned uses.

[Response Begins]

Public reporting

Professional Certification or Recognition Program

[Response Ends]

4a.03. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing), explain why the measure is not in use.

For example, do policies or actions of the developer/steward or accountable entities restrict access to performance results or block implementation?

[Response Begins]

There has long been support by multi-stakeholder groups that the S-CAHPS survey should have been included in the Physician Compare and PQRS programs as a stand-alone measure in addition to the CG-CAHPS because the CG-CAHPS does not accurately reflect care provided to the surgical patient. The support for the S-CAHPS has been

acknowledged by CMS as well as supported by the NQF Measures Applications Partnership (MAP). The S-CAHPS survey's initial NQF endorsement is also a testament to this.

For CY 2014-2016 proposed regulations, CMS received public comments to the PQRS program supporting the inclusion of the S-CAHPS as a stand-alone measure. Comments from The American College of Surgeons stated that the CG-CAHPS survey would not accurately reflect the care provided by single or multispecialty surgical or anesthesia groups. ACS also noted that S-CAHPS has been tested by the same standards as CG-CAHPS and follows the same collection mechanism as CG-CAHPS. In the 2014 Medicare Physician Fee Schedule final rule, several commenters opposed the publication of CG-CAHPS measures citing that the measures are not relevant to their particular specialty. They requested that CMS allow physicians the flexibility to select the survey instruments and patient satisfaction measures most appropriate for their practices, and many of the commenters recommended CMS use S-CAHPS as an optional patient experience of care measure. CMS responded that the Agency understands that CG-CAHPS is not the most applicable CAHPS survey for all specialties and service settings represented by groups on Physician Compare. Therefore, they explained that the Agency will evaluate the feasibility of including additional CAHPS surveys, such as S-CAHPS, on the site in the future.

In the 2015 Medicare Physician Fee Schedule final rule, CMS agreed that the S-CAHPS survey would be more relevant to a surgical group practice compared to the CG-CAHPS and noted that the majority of commenters supported the use of S-CAHPS in the PQRS program. However, CMS did not accept and finalize the measure. CMS explained "due to the cost and time it would take to find vendors to collect S-CAHPS data, it is not technically feasible to implement the reporting of the S-CAHPS survey measures for the 2017 or 2018 PQRS payment adjustments." They also note that Qualified Clinical Data Registries (QCDRs) will have the option to administer the S-CAHPS as a non-PQRS measure for the 2017 or 2018 PQRS payment adjustments (Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Final Rule, 79 Federal Register 219 November 13, 2014, page 67795).

Also in the 2015 Medicare Physician Fee Schedule final rule, several commenters noted the limitations of CAHPS for PQRS measures for some health care professionals and supported adding other types of patient experience data to Physician Compare, including the Surgical CAHPS and experience data collected via other sources. CMS agreed that Surgical CAHPS data is useful to consumers and explained that the Agency is exploring how it can incorporate this information into Physician Compare (Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Final Rule, 79 Federal Register 219 November 13, 2014, page 67777).

Similar comments were made by stakeholders in 2016 Medicare Physician Fee Schedule final rule, and similarly CMS explained that they understand that not all measures equally apply to all types of professionals included in Physician Compare, however, they believe the CAHPS for PQRS measures (ie. CG-CAHPS) apply to a large majority of professionals on the Physician Compare site (Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY2016, 80 Federal Register 220 November 16, 2015, page 71129).

Lastly, the NQF's MAP has recommended the inclusion of S-CAHPS for two consecutive years. In the MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS report the NQF MAP recommended the inclusion of S-CAHPS in the PQRS program. In the MAP 2014 Recommendations on Measures for More Than 20 Federal Programs, the MAP recommended the inclusion of the S-CAHPS measure in PQRS, Meaningful Use, the Value-based Payment Modifier, and Physician Compare. These reports can be found here:

MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. Final report available at: http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

MAP Pre-Rulemaking Report: 2014 Recommendations on Measures for More than 20 Federal Programs. Final report available at: http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx

[Response Ends]

4a.04. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes: used in any accountability application within 3 years, and publicly reported within 6 years of initial endorsement.

A 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.

[Response Begins]

A. Payment Program and Public Reporting

1. Name of program and sponsor: CMS Physician Compare
2. Purpose: Physician Compare is a national public reporting website which provides consumers with quality of care information to make informed health care decisions. Physician Compare is also intended to encourage clinicians to improve the quality of care they provide to their patients and create incentives to maximize performance.
3. Planned Use: Pending CMS approval for the 2018 MIPS program, participants in the American College of Surgeons (ACS) Surgeon Specific Registry (SSR) will have the option to report on components of the S-CAHPS as part of the Phases of Surgical Care Measures for the MIPS Qualified Clinical Data Registry (QCDR) reporting mechanism. The Phases of Surgical Care Measures are an episode-based measure framework which follows the five phases of surgical care: preoperative, perioperative, intraoperative, postoperative, and postdischarge. The measure set is composed of high-value process measures, appropriate S-CAHPS measures which correlates to the process measures, and surgical outcome measures. As part of this measure set, the S-CAHPS measures will be reported on the Physician Compare downloadable database if they meet CMS statistical public reporting standards which require that measures be valid, reliable, and accurate.
4. Geographic area and number and percentage of accountable entities and patients included: National Program. Percentage of entities and patients included will be determined in 2018.

B. Payment Program. Please see above in 4a1.1 for the use of S-CAHPS in the Quality Payment Program.

C. Professional Certification or Recognition Program

1. Name of program and sponsor: American Board of Surgery (ABS) Maintenance of Certification[®] (MOC) Part IV (Practice Assessment Resources) URL: <http://www.absurgery.org/default.jsp?exam-mocpa>
2. Purpose: The American Board of Surgery Maintenance of Certification Part IV can be satisfied by ongoing participation in a local, regional or national outcomes registry or quality assessment program. Components of the S-CAHPS will be available via the American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP), and the ACS Surgeon Specific Registry (SSR), starting in 2018. Both the SSR and NSQIP registries can meet the MOC Part IV MOC component, and are listed on the ABS website as examples of good programs for meeting Part 4, <http://www.absurgery.org/default.jsp?exam-mocpa>.
3. Geographic area and number and percentage of accountable entities and patients included: National Program. Percentage of entities and patients included will be determined in 2018.

[Response Ends]

4a.05. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

Detail 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.

[Response Begins]

Too early to broadly determine. However, as discussed in the Evidence form, several peer-reviewed studies have demonstrated the use of the S-CAHPS survey for local quality improvement purposes with good success.

[Response Ends]

4a.06. Describe the process for providing measure results, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

[Response Begins]

[Response Ends]

4a.07. Summarize the feedback on measure performance and implementation from the measured entities and others. Describe how feedback was obtained.

[Response Begins]

[Response Ends]

4a.08. Summarize the feedback obtained from those being measured.

[Response Begins]

[Response Ends]

4a.09. Summarize the feedback obtained from other users.

[Response Begins]

[Response Ends]

4a.10. Describe how the feedback described has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

[Response Begins]

[Response Ends]

4b.01. You may refer to data provided in Importance to Measure and Report: Gap in Care/Disparities, 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, provide an explanation. 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.

[Response Begins]

There is no repository for S-CAHPS data. Trend data is not available. Surgeons use S-CAHPS to identify their strengths and weaknesses and to help develop strategies for improving patients' experiences with care delivered surrounding a surgery.

The objective of the S-CAHPS survey is to measure aspects of surgical quality that are important to consumers and for which consumers are the best source of information. At the same time, consistent with the survey, the measures aim to directly benefit a variety of users, including: patients, practice groups, health plans, insurers, and specialty boards. Each group has a need for information regarding the quality of surgeons and surgical care.

1. Patients will use information from the measures to help make better and more informed choices about their surgical care.
2. Practices, health plans, and insurers will use the measure results for quality improvement initiatives and incentives.
3. Specialty boards may use the measure results for maintenance of certification purposes.

[Response Ends]

4b.02. Explain any unexpected findings (positive or negative) during implementation of this measure, including unintended impacts on patients.

[Response Begins]

No unexpected findings have been uncovered.

[Response Ends]

4b.03. Explain any unexpected benefits realized from implementation of this measure.

[Response Begins]

[Response Ends]

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.

If you are updating a maintenance measure submission for the first time in MIMS, please note that the previous related and competing data appearing in question 5.03 may need to be entered in to 5.01 and 5.02, if the measures are NQF endorsed. Please review and update questions 5.01, 5.02, and 5.03 accordingly.

5.01. Search and select all NQF-endorsed related measures (conceptually, either same measure focus or target population).

(Can search and select measures.)

[Response Begins]

[Response Ends]

5.02. Search and select all NQF-endorsed competing measures (conceptually, the measures have both the same measure focus or target population).

(Can search and select measures.)

[Response Begins]

[Response Ends]

5.03. If there are related or competing measures to this measure, but they are not NQF-endorsed, please indicate the measure title and steward.

[Response Begins]

[Response Ends]

5.04. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s), indicate whether the measure specifications are harmonized to the extent possible.

[Response Begins]

Yes

[Response Ends]

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

[Response Begins]

In December 2011, the Agency for Healthcare Research and Quality released the 2.0 version of the Surgical Care Survey. This update keeps the Surgical Care Survey consistent with the Clinician & Group Survey, which was updated in October 2011. Because the changes that led to the 2.0 designation do not represent a significant digression from the 1.0 version of this survey, the shift from 1.0 to 2.0 does not affect the ability of survey users to assess trends in performance.

[Response Ends]

5.06. Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality). Alternatively, justify endorsing an additional measure.

Provide analyses when possible.

[Response Begins]

The Surgical Quality Alliance (SQA; <https://www.facs.org/advocacy/quality/surgical-quality-alliance>) reviewed the current CAHPS[®] Clinician and Group Survey and identified critical gaps in content and approach related to the assessment of surgical care. For example, some critical gaps in the survey include informed consent, shared decision making, anesthesia care, and post-operative instructions and access, all of which are issues consumers find to be very important in surgery. Therefore, the SQA felt that the development of a surgical patient experience survey fit well into the mission to improve the quality of healthcare delivered to surgical patients.

Surgeries have high resource use, and poor quality can have serious consequences for patients, including death. Hospital stays that involve operating room (OR) procedures are more costly, on average, than stays that do not involve OR procedures. Therefore, improving the quality of surgical care is of paramount importance to patients and the healthcare system alike. To measure the quality of surgical care in the U.S., a survey that measures the patient-reported outcomes associated with care provided by single- or multispecialty surgical or anesthesia groups is necessary. As shown in the attached support letter from 2012, there is much support from the surgical specialty societies for NQF endorsement and use of the S-CAHPS survey. (See attached "Attachment C Main 1c3 Letter to NQF 2012_surgeryspecialty_1741.pdf".)

The Centers for Medicare and Medicaid Services (CMS) acknowledged the importance of allowing for the administration of S-CAHPS reporting in addition to the Clinician and Group CAHPS for Physician Quality Reporting System (PQRS). The ACS has emphasized to CMS that it is critical that the measures included in the quality-tiering composite are valid, reliable, and applicable to all health care professionals, to avert the unintended consequence of misclassifying a physician's care and unfairly affecting payment. Accordingly, the S-CAHPS measures have been submitted for consideration for the Merit-based Incentive Payment System of the Quality Payment Program.

Though the main emphasis of the survey is to measure aspects of surgical quality that are important to consumers and for which consumers are the best source of information, the development of measures specific to surgical care benefits many users, including: patients, practice groups, health plans, insurers, and specialty boards. Each group has a need for information regarding the quality of surgeons and surgical care. Patients will use information from the survey to help make better and more informed choices about their surgical care. Practices, health plans, and insurers will use the surgical survey results for quality improvement initiatives and incentives. Specialty boards may use the survey's measure results for maintenance of certification purposes.

CAHPS surveys were originally developed to meet the need of consumers for usable, relevant information on quality of care from the patient's perspective. But they also play an important role as a quality improvement (QI) tool for health care organizations, which can use the standardized data to identify relative strengths and weaknesses in their performance, determine where they need to improve and track their progress over time.

Cultivating the use of CAHPS surveys for QI purposes is one of the key objectives for the CAHPS grants. The CAHPS Improvement Guide is a comprehensive resource for health plans, medical groups, and other providers seeking to improve their performance in the domains of quality measured by CAHPS surveys. The guide may be used to:

- Cultivate an environment that encourages and sustains quality improvement;
- Analyze the results of CAHPS surveys to identify strengths and weaknesses; and
- Develop strategies for improving performance.

[Response Ends]

Appendix

Supplemental materials may be provided in an appendix.:

Contact Information

Measure Steward (Intellectual Property Owner):

Measure Steward Point of Contact:

Measure Developer if different from Measure Steward:

Measure Developer Point(s) of Contact:

Additional Information

1. Provide any supplemental materials, if needed, as an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be collated one file with a table of contents or bookmarks. If material pertains to a specific criterion, that should be indicated.

[Response Begins]

[Response Ends]

2. List the workgroup/panel members' names and organizations.

Describe the members' role in measure development.

[Response Begins]

Surgical Quality Alliance (SQA) Technical Advisory Panel (TAP):

1. Priscilla Arnold, MD FACS - American Society of Cataract and Refractive Surgery
2. Larissa Temple, MD FACS - American Society of Colon and Rectal Surgeons
3. Laura King, MD – American Academy of Ophthalmology
4. Robin Brody, MD – American Academy of Otolaryngology – Head and Neck Surgery
5. Lee Eisenberg, MD FACS - American Academy of Otolaryngology – Head and Neck Surgery
6. Rahul Shah, MD FACS - American Academy of Otolaryngology – Head and Neck Surgery
7. Robert Haralson, MD FACS – American Academy of Orthopaedic Surgeons
8. Frank Opelka, MD FACS – American College of Surgeons
9. Antony Sidawy, MD FACS - Society for Vascular Surgery
10. Loren Hiratzka, MD FACS – Society for Thoracic Surgery
11. James Hicks, MD – American Society of Anesthesiologists
12. Andrea Pusic, MD FACS - American Society of Plastic Surgeons
13. Sharon Merrick, Staff - American Society of Anesthesiologists
14. Chip Amoe, Staff - American Society of Anesthesiologists
15. Jason Byrd, Staff - American Society of Anesthesiologists
16. Cathy Cohen, Staff - American Academy of Ophthalmology
17. Cherie McNett, Staff - American Academy of Ophthalmology
18. Kristine Schulz, Staff - American Academy of Otolaryngology - Head and Neck Surgery
19. Stephanie Jones, Staff - American Academy of Otolaryngology - Head and Neck Surgery
20. Beth Kosiak, Staff - American Urological Association
21. Suzanne Pope, Staff - American Urological Association
22. Nancey McCann, Staff - American Society of Cataract and Refractive Surgery
23. DeLaine Schmitz, Staff - American Society of Plastic Surgeons
24. Guy Beaumont, Staff – American College of Osteopathic Surgeons
25. Cynthia Shewan, Staff – Society for Thoracic Surgery
26. Elizabeth Hoy, Staff – American College of Surgeons
27. Caitlin Burley, Staff - American College of Surgeons
28. Valerie Oster, Staff - American College of Surgeons
29. Andrea Burling – American Institutes for Research
30. Roger Levine - American Institutes for Research
31. Samantha Sheridan - Westat
32. John Rauch – Westat

The Surgical quality Alliance (SQA) of the American College of Surgeons includes a Technical Advisory Panel (TAP) which provided continuous support to the development of the Surgical care Survey from the literature review to final testing. The TAP included 32 members from various surgery and anesthesiology specialty societies, each having technical expertise in the topic of surgical care.

[Response Ends]

3. Indicate the year the measure was first released.

[Response Begins]

[Response Ends]

4. Indicate the month and year of the most recent revision.

[Response Begins]

[Response Ends]

5. Indicate the frequency of review, or an update schedule, for this measure.

[Response Begins]

Periodic, as needed

[Response Ends]

6. Indicate the next scheduled update or review of this measure.

[Response Begins]

[Response Ends]

7. Provide a copyright statement, if applicable. Otherwise, indicate "N/A".

[Response Begins]

"CAHPS" is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ) but CAHPS surveys themselves are not copyrighted and in the public domain.

[Response Ends]

8. State any disclaimers, if applicable. Otherwise, indicate "N/A".

[Response Begins]

None.

[Response Ends]

9. Provide any additional information or comments, if applicable. Otherwise, indicate "N/A".

[Response Begins]

List of Attachments:

Attachments located in zip file named: Attachments 1741 11062017.zip

Attachment A Main S9 CY2015-90-day-global codes.xlsx

Attachment B Main 1b2 S-CAHPS_score_Tables.xlsx

Attachment C Main 1c3 Letter to NQF 2012_surgeryspecialty_1741.pdf

Attachment D Main 1c5 Surgical CAHPS Focus Groups_2nd Round_2010.pdf

[Response Ends]

