



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 #: 3227

Corresponding Measures:

De.2. Measure Title: CollaboRATE Shared Decision Making Score

Co.1.1. Measure Steward: The Dartmouth Institute for Health Policy & Clinical Practice

De.3. Brief Description of Measure: CollaboRATE is a patient-reported measure of shared decision making which contains three brief questions that patients, their parents, or their representatives complete following a clinical encounter. The CollaboRATE measure provides a performance score representing the percentage of adults 18 and older who experience a high level of shared decision making.

The measure was developed to be generic and designed so that it could apply to all clinical encounters, irrespective of the condition or the patient group. The measure asks the patient to evaluate the 'effort made' to inform, to listen to issues that matter to the patient, and to include those issues in choosing 'next steps'. The items were co-developed with patients using cognitive interview methods.

CollaboRATE is designed for use in routine health care delivery. The brevity and the ease of completion were purposeful so the measure could be used as a performance metric for shared decision making.

1b.1. Developer Rationale: Measuring the level of shared decision making in the clinical encounter from the patient's perspective is an important part of assessing healthcare quality and provider performance. CollaboRATE scores can provide important data to help facilitate quality improvement efforts across organizations.

Feedback from patients completing the survey demonstrates that they value being asked specifically about shared decision-making and being able to provide feedback on that topic. This patient feedback was obtained as part of a cognitive interview and pilot survey study (Elwyn 2013, doi: 10.1016/j.pec.2013.05.009). Participants in the pilot study (n=30) reported favorable views on the focus of the collaboRATE items, exemplified by participant quotations such as: "As many times as I have been here, I have never had a question like that. I think it's a damn good question."

S.4. Numerator Statement: Shared decision making; top-box scores represent the proportion of patients perceiving a high level of shared decision-making.

S.6. Denominator Statement: The denominator consists of all patients who complete the three CollaboRATE items. The denominator may include patients of any demographic or clinical background, as the measure is generic and applicable to a variety of clinical situations.

S.8. Denominator Exclusions: All patients are eligible to complete collaboRATE. Only incomplete collaboRATE responses should be excluded from the denominator.

De.1. Measure Type: Outcome: PRO-PM

S.17. Data Source: Instrument-Based Data

S.20. Level of Analysis: Clinician : Group/Practice

IF Endorsement Maintenance – Original Endorsement Date: Oct 25, 2019 **Most Recent Endorsement Date:** Oct 25, 2019

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

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

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – 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.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[nqf_evidence_CollaboRATE_7.1_for_Jan_2019-636915512450013820.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.

1b. Performance Gap

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

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

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

IF a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

IF a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

Measuring the level of shared decision making in the clinical encounter from the patient's perspective is an important part of assessing healthcare quality and provider performance. CollaboRATE scores can provide important data to help facilitate quality improvement efforts across organizations.

Feedback from patients completing the survey demonstrates that they value being asked specifically about shared decision-making and being able to provide feedback on that topic. This patient feedback was obtained as part of a cognitive interview and pilot survey study (Elwyn 2013, doi: 10.1016/j.pec.2013.05.009). Participants in the pilot study (n=30) reported favorable views on the focus of the collaboRATE items, exemplified by participant quotations such as: "As many times as I have been here, I have never had a question like that. I think it's a damn good question."

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

Three Group Primary Care Survey

In a study of 3 medical groups, collaboRATE performance scores were compared across groups. All consecutive adult patients visiting the three primary care groups during their respective survey periods (between April 2014-October 2015) were eligible to complete CollaboRATE. One group was in Lebanon, NH with a patient population of 16,000; a second group was in Palo Alto, CA with a patient population of 13,000; the third group was in Chelsea, MA with a patient population of 14,000. Across the three sites, 5974 patient collaboRATE responses were collected: 4421 in group 1, 323 in group 2, and 1230 in group 3. Performance score data, shown in the table below, demonstrate a gap in collaboRATE performance scores between medical groups.

Mean score: 72%

Standard deviation: 9

Score range (min-max): 68%-86%

Interquartile range: --

Scores by decile: --

Number of measured entities: 3
Number of patient reports: 5974

California Medical Group Survey

California Medical Group data were collected as part of the Patient Assessment Survey (PAS) administered by the Pacific Business Group on Health. This survey is comprised of the Clinician-Group CAHPS instrument plus CollaboRATE and other items of interest. CollaboRATE performance scores were compared across medical groups. The California Medical Group Survey included 31,265 respondents, with 16,627 answering based on a primary care visit and 14,638 answering based on a specialty care visit. Participants are from a random sample of adult and pediatric visits by insured patients across 153 California medical groups, including both primary and specialty outpatient care. Performance score data, shown in the table below, demonstrate a gap in collaboRATE performance scores between medical groups.

Mean score: 60%

Standard deviation: 7

Score range (min-max): 36%-75%

Interquartile range: 8

Scores by decile: 50%, 54%, 56%, 58%, 60%, 61%, 62%, 64%, 67%, 71%

Number of measured entities: 153

Number of patient reports: 31,265

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

CollaboRATE was created with substantial input from patients and laypeople to address a lack of existing measurement tools in the area of patient engagement and shared decision-making that: 1) can be administered close to the time of the encounter to enhance recall; 2) are brief and easy to complete to reduce burden of both data collection and patient response; 3) specific to the core constructs of shared decision-making, namely information sharing, preference elicitation, and preference integration (Elwyn G, Barr PJ, Grande SW, Thompson R, Walsh T, Ozanne EM. 2013. Developing CollaboRATE: a fast and frugal patient-reported measure of shared decision making in clinical encounters. doi:10.1016/j.pec.2013.05.009; Barr PJ, Thompson R, Walsh T, Grande SW, Ozanne EM, Elwyn G. 2015. The Psychometric Properties of CollaboRATE: A Fast and Frugal Patient-Reported Measure of the Shared Decision-Making Process. doi:10.2196/jmir.3085).

Testing has shown variation in CollaboRATE performance scores across clinicians, with scores ranging from 61% to 81% across three clinics and from 42% to 99% across clinicians.

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

Preliminary research in Chelsea, MA, an area where the population has low socio-economic status and high levels of immigration and diversity, has shown similar scores between those patients completing CollaboRATE in English (CollaboRATE score=86%, n=624) and those completing it in Spanish (CollaboRATE score=86%, n=606). However, among respondents to the English version (n=586), scores were higher among patients who did not have a language interpreter present during their medical appointments (CollaboRATE score=88%, n=517) than among those who had a language interpreter present (CollaboRATE score=74%, n=69), suggesting that patients with less English familiarity who required an interpreter experienced poorer shared decision-making.

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

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

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

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

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

<http://www.glynelwyn.com/collaborate-measure.html>

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

This is not an eMeasure Attachment:

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

No data dictionary Attachment:

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

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

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

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

[Shared decision making; top-box scores represent the proportion of patients perceiving a high level of shared decision-making.](#)

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

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

[The numerator consists of those cases \(i.e. patient responses\) where perfect scores are given on all three CollaboRATE items; cases with perfect scores are coded '1', whereas all other patient scores are coded '0' in a dichotomous top score outcome variable.](#)

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

The denominator consists of all patients who complete the three CollaboRATE items. The denominator may include patients of any demographic or clinical background, as the measure is generic and applicable to a variety of clinical situations.

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

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

CollaboRATE is applicable to all patients; the denominator therefore consists of all complete responses.

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

All patients are eligible to complete collaboRATE. Only incomplete collaboRATE responses should be excluded from the denominator.

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

Exclude from the denominator any cases in which there are missing responses on any of the three collaboRATE items.

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

We do not stratify by patient or provider level characteristics, although there may be analytic interest in these variables. If responses are collected for patients of all ages, it may be appropriate to stratify by pediatric and adult patients.

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

Statistical risk model

If other:

S.12. Type of score:

Rate/proportion

If other:

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

Better quality = Higher score

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

To calculate CollaboRATE Performance Score:

Exclude cases (i.e. patient survey responses) where a response to one or more of the CollaboRATE questions is missing. Code each case as either '1', if the response to all three CollaboRATE items was 9, or '0' if the response to any of the three CollaboRATE items was less than 9. To case-mix adjust scores, conduct logistic regression analysis with the binary collaboRATE score outcome as the dependent variable and independent variables including patient age and patient gender; predict probabilities at the medical group level based on this model. These probabilities are the CollaboRATE performance scores for each medical group. Higher scores represent more shared decision making. This number also corresponds to the case-mix adjusted proportion of patients who perceive 'gold standard' shared decision making.

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

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Due to collaboRATE's broad applicability to a wide variety of clinical contexts, the sample can consist of all consecutive patients. Consecutive patient samples are more feasible for timely implementation in routine practice than random samples, while also

minimizing selection bias as compared to convenience sampling. In determining an optimal sampling strategy for a given use of collaboRATE, and especially when considering consecutive sampling, seasonal and time-dependent trends that affect patient flow should be taken into account. A minimum of 25 responses per unit of analysis is required (Chisholm & Askham, 2006, What do you think of your doctor: a review of questionnaires for gathering patients' feedback on their doctor).

CollaboRATE was designed to be applicable to all clinical settings and any type of healthcare decision - from minor and sometimes implicit decisions like continuing with an already-established treatment plan to major decisions such as designing a brand new treatment plan. In developing the measure together with target end-users, we confirmed the measure was usable and understandable in a wide variety of clinical contexts and circumstances for assessing the core components of shared decision-making, i.e. 1) information provision; 2) preference elicitation; and 3) preference integration.

Proxy responses are allowed depending on the specific target population. A proxy version of the measure for parents can be found at: http://www.glynelwyn.com/uploads/2/4/0/4/24040341/collaborate_forparents_v4_1.pdf. A proxy version for other individuals acting on behalf of patients can be found at:

http://www.glynelwyn.com/uploads/2/4/0/4/24040341/collaborate_forproxies_v2_1.pdf.

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

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

At survey administration, we aim for a 30-40% response rate. If administered within the clinic setting, surveys should be administered in a private area to ensure confidentiality of responses and minimize potential influence of clinic staff on survey responses. To facilitate survey administration, electronic (e.g. text message, telephone) and online (e.g. patient portal) methods are recommended.

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

If other, please describe in S.18.

Instrument-Based Data

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

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Multiple modes of data collection, including: Paper-based, tablet, text messages (SMS), online patient portal, and interactive voice response (automated telephone calls). Tool is adaptable for use across multiple data collection modalities.

Measure is available in English, Spanish, Dutch, Norwegian, Danish, and French.

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

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

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

Clinician : Group/Practice

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

Inpatient/Hospital, Outpatient Services

If other:

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

Not applicable.

2. Validity – See attached Measure Testing Submission Form

[nqf_testing_attachment_7.1_CollaboRATE_final_for_Jan_2019.docx](#), [Appendix_1_-_Stata_output_for_signal-to-noise_analysis_final_for_Jan_2019.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$; correlation of x or higher; patient factors should be present at the start of care)

What were the statistical results of the analyses used to select risk factors?

Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

Other

If other: Patient-reported CollaboRATE data may be collected by clinic staff at the point of care, through the clinic's electronic or telephone outreach to patients following their clinic visits, or by a third party.

3b. Electronic Sources

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

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

Patient/family reported information (may be electronic or paper)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM). CollaboRATE has been tested on a tablet, and using a web-based platform (online patient portal weblink sent by email). We have also successfully collected data using responses to text messages (SMS) on cellular telephones.

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

Attachment:

3c. Data Collection Strategy

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

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

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

We have learned that ensuring patient confidentiality at the time of survey completion allows for greater variation in the range of scores. Feasibility issues with regard to data collection are more prominent with paper surveys administered in clinic; automated patient surveys administered via text message or online patient portal require less staff time to administer and allow respondents more flexibility.

We recommend limiting data collection to 25 patients per unit of analysis to minimize response burden for patients. Clinicians whose performance is being measured have expressed interest in the measure, asking for details on how they can improve their performance; we recommend making these resources available to entities whose performance is being measured.

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

The measure is licensed under Creative Commons and freely available online at <http://glynelwyn.com/collaborate-measure.html>. There are no fees associated with use of the measure.

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

Specific Plan for Use	Current Use (for current use provide URL)
	Payment Program Blue Shield of California http://healthaffairs.org/blog/2016/03/28/an-innovative-patient-centered-total-joint-

	replacement-program/ Quality Improvement (external benchmarking to organizations) Pacific Business Group on Health http://www.pbgh.org/programs/21-the-patient-assessment-survey Right for Me http://www.rightforme.org/right-for-me.html Evaluating CollaboRATE Evaluating CollaboRATE, http://bmjopen.bmj.com/content/7/3/e014681 Quality Improvement (Internal to the specific organization) United States Department of Veterans Affairs https://www.va.gov/
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4a.1. For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

Name of program and sponsor: Blue Shield of California

Purpose: Quality improvement

Geographic area and number and percentage of accountable entities and patients included: State of California; 100% of Blue Shield members requesting pre-authorization for total joint replacement or hysterectomy procedures.

Level of measurement: Other (Individual patient)

Setting: Outpatient Services

Name of program and sponsor: US Department of Veterans Affairs; Dr. Barbara Bokhour

Purpose: Research

Geographic area and number and percentage of accountable entities and patients included: VA Medical Center, Bedford, MA; 1019 outpatient respondents and 767 inpatient respondents.

Level of measurement: Clinician: Individual

Setting: Inpatient/Hospital; Outpatient Services

Name of program and sponsor: Pacific Business Group on Health

Purpose: Quality Improvement

Geographic area and number and percentage of accountable entities and patients included: State of California; 31,000 patient respondents who visited one of 150 participating provider groups, demonstrating variation in CollaboRATE performance scores across clinicians and provider groups, with provider group-level scores ranging from 40% to 68%.

Level of measurement: Clinician: Group/Practice

Setting: Outpatient Services

Name of program and sponsor: Right for Me, Dartmouth College and PCORI

Purpose: Research

Geographic area and number and percentage of accountable entities and patients included: Cluster randomized controlled trial including 16 clinics/provider groups in New England demonstrated variation in CollaboRATE performance scores across clinics.

Level of measurement: Clinician: Individual; Clinician: Group/Practice

Setting: Outpatient Services

Name of program and sponsor: Evaluating CollaboRATE, Dartmouth College and Moore Foundation

Purpose: Research

Geographic area and number and percentage of accountable entities and patients included: Three clinics/provider groups in New England and California, including more than 5,000 patient CollaboRATE responses, demonstrated variation in CollaboRATE performance scores across clinics. At one clinic with more than 4,000 patient responses, clinician-level scores changed with varying survey administration modes, though clinician rank order remained consistent across all survey administration modes.

Level of measurement: Clinician: Individual; Clinician: Group/Practice

Setting: Outpatient Services

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

Not applicable. There are no policies in place to restrict access to performance results or impede implementation.

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

Not applicable.

Improvement

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

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

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

Performance results can be compared across entities to illustrate variation in shared decision making across clinicians, practices, facilities, and health systems. Widespread data collection is currently underway by payers (e.g. Blue Shield of California) and entities such as the Pacific Business Group on Health (who have collected more than 30,000 CollaboRATE responses to date across multiple health care practices in California) to determine how shared decision making performance varies across providers and systems with a goal of improving shared decision making and resulting health care quality for individuals and populations.

4c. Unintended Consequences

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

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

No unintended negative consequences to individuals or populations were identified during testing. Clinical testing included 15 months of routine data collection in a primary care clinic, where all patients visiting participating clinicians were eligible to complete CollaboRATE. A total of 4421 CollaboRATE responses were collected during this testing period with no unintended negative consequences identified.

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

Feedback from patients completing the survey demonstrates that individuals value being asked specifically about shared decision making and being able to provide feedback on that topic (Elwyn 2013, doi: 10.1016/j.pec.2013.05.009).

Clinicians who participated in a 15-month CollaboRATE data collection period gathered for a focus group at the end of data collection, at which they expressed interest in the CollaboRATE measure and in their performance scores and how they might improve their shared decision-making performance.

4d1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

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

Following 15 months of data collection in a primary care clinic, participating clinicians received single-page reports detailing their

results and comparing their scores to those of their anonymous colleagues. These reports were accompanied by a seminar in which Glyn Elwyn presented shared decision-making theory and best practices.

4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Score reports were provided to participating clinicians at the end of data collection. An educational seminar was scheduled during a clinic faculty meeting where Glyn Elwyn presented shared decision-making theory, best practices, and methods for improving CollaboRATE scores.

4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

Measured entities have provided feedback on implementing the collaboRATE tool into their practices based on diverse implementation strategies and experiences. The brief nature of the measure and its ability to be completed by most patients in under 30 seconds contributes to its ease of use. Paper-based survey implementation within the clinic environment was seen as a challenge due to the personnel and related resources required to administer the paper questionnaire to patients. This challenge was surmountable, particularly through automated questionnaire delivery via text messages (SMS), automated phone calls, and online patient portals (e.g. MyChart). Feedback related to automated questionnaire administration has been positive due to its limited impact on clinic workflows and few ongoing resource requirements after initial set-up.

4d2.2. Summarize the feedback obtained from those being measured.

N/A

4d2.3. Summarize the feedback obtained from other users

N/A

4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

N/A

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

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

2962 : Shared Decision Making Process

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

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications harmonized to the extent possible?

Yes

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

The measure specifications are not completely harmonized as CollaboRATE's target population is more inclusive than measure 2962 of Shared Decision Making Process, which focuses on patients undergoing specific surgical procedures. Instead, CollaboRATE allows for assessment of shared decision-making performance relevant to any type of health care encounter, context, or setting.

5b. Competing Measures

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

OR

Multiple measures are justified.

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

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

Not applicable.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment **Attachment:** [Appendix_2_-_Testing_attachment_-_Medical_group_signal-to-noise_calculations_final_for_Jan_2019.xlsx](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [The Dartmouth Institute for Health Policy & Clinical Practice](#)

Co.2 Point of Contact: [Glyn, Elwyn, \[glynelwyn@gmail.com\]\(mailto:glynelwyn@gmail.com\), 603-729-6694-](#)

Co.3 Measure Developer if different from Measure Steward: [The Dartmouth Institute for Health Policy & Clinical Practice](#)

Co.4 Point of Contact: [Glyn, Elwyn, \[glynelwyn@gmail.com\]\(mailto:glynelwyn@gmail.com\), 603-729-6694-](#)

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

Individuals involved in the development of the measure, including interviews with target end users and pilot testing, include: [Glyn Elwyn, Paul Barr, Rachel Thompson, Stuart Grande, Thom Walsh, Elissa Ozanne, and Rachel Forcino.](#)

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: [2013](#)

Ad.3 Month and Year of most recent revision:

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

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

Ad.6 Copyright statement: [CollaboRATE is registered under a Creative Commons license and is freely available for use.](#)

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: