June 1, 2015

VIA ELECTRONIC SUBMISSION

Howard Shelanski, OIRA Administrator
Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer
725 17th Street, NW
Washington, DC 20503

Re: Document Identifier CMS-10500; Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS)

Dear Administrator Shelanski:

On behalf of the ASC Quality Collaboration (ASC QC), a cooperative effort of organizations and companies interested in ensuring ambulatory surgical center (ASC) quality data is appropriately developed and reported, please accept the following comments regarding Document Identifier CMS-10500, also known as the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) (80 FR 24935). The ASC QC’s stakeholders include ASC corporations, ASC industry associations, physician and nursing professional societies, and accrediting bodies with an interest in ASCs. Please see Appendix A for a list of the ASC QC’s participating organizations.

We support the use of a standardized survey instrument focusing on the patient’s experience of care provided by an outpatient surgical facility. We are pleased the OAS CAHPS addresses the experience of surgical care received in both hospital-based outpatient surgical departments (HOSDs) and ASCs, increasing opportunities for consumers to make meaningful comparisons across outpatient surgical facility settings.

We appreciate the investment CMS has made in developing and obtaining CAHPS accreditation for this survey. We are pleased by the improvements resulting from the recent CAHPS review. However, we continue to have strong reservations regarding the instrument. We are particularly concerned that the survey will prove unduly expensive when compared to the typical ASC process for evaluating patient experience (the Ambulatory Surgery Center Association’s Outcomes Monitoring Project, fielded quarterly, typically finds that virtually all participating ASCs - over 99 percent of respondents - use a patient survey), and that this burden will lead centers to forego voluntary use of the OAS CAHPS.

This notice requests "comments regarding the burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency’s functions; (2) the
accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.” We trust you will appreciate the breadth and depth of our collective expertise in the ASC industry, take our recommendations seriously, and make appropriate adjustments to lower the administrative burden of the survey.

I. The Collection Imposes Unnecessary Burdens That Could Be Readily Mitigated

As we have stated repeatedly in our remarks to CMS (March 2013 response to CMS-4171-NC, December 2013 comments regarding CMS-10500, and March 2015 comments regarding CMS-10500), it is imperative to keep the administrative and financial burden associated with this survey as low as possible. In the past, CMS has acknowledged that ASCs are predominantly small providers; approximately 73 percent of ASCs would be classified as small businesses according to the Small Business Administration size standards [72 Fed. Reg. 66901]. The predominance of small facilities is corroborated by CMS data that indicates a median of two operating/procedure rooms per facility (mean = 2.5).

In the Support Statement for this collection of information, CMS states under Section A.5 Involvement of Small Entities, “Survey respondents are patients who have received care from a hospital-based outpatient surgery center or independently owned ASC. The survey should not impact small businesses or other small entities.” While it’s true that the survey’s respondents are patients, the entities expected to pay for the administration of the survey during the national implementation – who are thereby naturally and unavoidably impacted - include ASCs, the majority of which are small businesses. CMS has made no provision to reduce burden, and is instead planning to implement the survey under conditions that are unnecessarily burdensome. In particular, we note the following:

- CMS is not incorporating information technology solutions into the modes of survey administration, thereby failing to take advantage of an important opportunity to reduce burden and unnecessarily increasing costs to ASCs.
- CMS does not plan to allow survey administration options that substantially reduce the cost to ASCs.
- CMS is expecting OAS CAHPS participants to meet a threshold of 300 completed surveys annually, which is more than it expects hospitals to complete each year to produce statistically valid results for participation in the agency’s Hospital Value-Based Purchasing Program and the HCAPHS Star Ratings Initiative, part of the CMS Hospital Inpatient Quality Reporting Program.
- The OAS CAHPS is longer than the Hospital CAHPS, imposing additional and unwarranted financial burden on ASCs.

A. Failure to Use Information Technology to Minimize Burden

This Notice specifically requests public comment on the use of information technology to minimize the information collection burden associated with the OAS CAHPS. As we have
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repeatedly stated in our comments regarding this survey, information technology should be employed to the fullest extent possible to keep burden low. Specifically, two information technology solutions should be implemented in order to minimize information collection burden: the use of electronic mail with mail or telephone as a mixed mode administration option, and the use of a web-based survey administration mode. Both information technology solutions are already in use in other patient experience surveys: the CAHPS® Surgical Care Survey may be administered using mixed modes involving electronic mail, and web-based patient surveys are already successfully used by many leading healthcare market research firms.

In its Supporting Statement CMS states, “[a]ny additional forms of information technology, such as web surveys, would be less feasible with OAS CAHPS patients, as patient e-mail address information is not readily available through HOPDs and ASCs.” This statement is manifestly untrue! Patient email addresses can be, and are, as readily collected as the patient’s address and phone number. It is hard to understand why, when information technology is ubiquitous in daily life in the United States, CMS is not considering its use in the modes of administration for this survey.

In the past, CMS has expressed reluctance to offer these information technology solutions because of its impression that Medicare beneficiaries or poor households would be unlikely to respond online. However, data from other government agencies indicates that the use of enabling technology is not only prevalent, but also expanding rapidly amongst all Americans regardless of age, sex, educational attainment, household income, and employment status. We encourage the review of the most recent data from the US Census Bureau regarding Internet use, which is included in its dataset titled Computer and Internet Use in the United States: 2013, released in November 2014. (Note particularly that the number of individuals age 65 years and older living in a house with a computer has increased to 71.0 percent from 61.8 percent just two years earlier. Also of interest is that while in 2011 45.5 percent of individuals age 65 and older accessed the Internet from some location, the number living in a house with Internet use had grown to 64.3 percent in 2013.) The National Telecommunications & Information Administration of the US Department of Commerce has recently issued two pertinent items pointing to significant growth in the use of the Internet over time in all age groups. Both, Exploring the Digital Nation: America’s Emerging Online Experience and Exploring the Digital Nation: Embracing the Mobile Internet, are available online. The latter report states, “some form of broadband, whether fixed or mobile, is now available to almost 99 percent of the U.S. population [emphasis added].”

Our members consistently report achieving significant cost savings by incorporating the use of electronic mail and web-based survey administration into their patient survey methodologies. Most centers have seen savings of 50%, and some have seen savings of up to 75% from third-party survey vendors. These savings opportunities are substantial and should not be ignored. (As an added benefit to an electronic approach, our members report substantially higher survey responses rates of up to 60%.)

Steps must be taken now to ensure the use of information technology is incorporated in the administration of the OAS CAHPS. Failing to incorporate electronic mail and a web-based survey in the mode experiment and subsequent national implementation cannot be justified in
the light of current information technology adoption in the United States. To proceed as CMS has outlined in its Supporting Statement leaves ASCs in the position of having to shoulder entirely avoidable costs.

B. Administration Options Will Cause Undue Burden and Reduce the Usefulness of the Results

Multiple survey administration options should be permitted, allowing ASCs to choose the most affordable approach for their facility. Alternatives should include administration through a third-party vendor, self-administration for an individual facility, and self-administration for multiple facilities. Requiring the use of a CMS-approved survey vendor will be an additional and undue financial burden to many ASCs, who are already faced with a multitude of costly Federal requirements.

ASCs should have the option to distribute the survey at the point of care upon the patient’s discharge from the center to help control the cost per returned survey. It is commonplace for an ASC to give their current survey instrument to the patient while they are on site, with instructions to complete the survey after discharge. Having a vendor distribute the surveys will increase the cost. Note that we do not recommend on-site administration of the survey to the patient for a number of reasons, including the introduction of bias, the potential impact of recent sedation or anesthesia, and insufficient time having elapsed for the patient’s assessment of self-reported outcomes.

Distributing the survey at the time of discharge would also promote more timely and accurate responses. The process CMS has outlined would result in patients receiving their survey roughly one to two months after the date of service. This delay will negatively impact the patient’s ability to accurately recall all that happened during their visit. Details of the education and explanations received not only at the time of service, but also in advance (during the pre-operative visit to their surgeon and the pre-operative phone call from the facility) are likely to be forgotten.

C. The Minimum Number of Completed Surveys Exceeds Thresholds Set for Other Providers

In its Supporting Statement under Section B.1.2b National Implementation Sampling Specifics, CMS states, “[a] minimum of 300 completed surveys annually is the target for each participating outpatient facility. If a facility patient volume is too small to yield 300 completed surveys per year, a census will be surveyed. The 300 completed surveys needed for analysis is derived from the formula for the precision of a proportion with the estimate at 0.5, the confidence interval of about +/- 0.05, and a confidence level of 95%. The number of patients needed to be selected each month to yield a minimum of 300 completed surveys per year will ultimately be determined by each facility and its survey vendor.”

This 300-survey threshold is three times higher than that seen in other CMS programs. For example, CMS sets a threshold of 100 completed surveys for hospital participation in its HCAPHS Star Ratings initiative under the Hospital Inpatient Quality Reporting Program. This is
the same standard used in the Hospital Value-Based Purchasing Program. Setting higher expectations for smaller providers like ASCs is not reasonable or acceptable. The minimum number of completed surveys ASCs are expected to attain should be no more than the minimum required for hospitals.

In addition, a significant minority of ASCs treat less than 938 patients each year, the sample size needed to assure 300 respondents using CMS’s assumed response rate of 32% for mail only or telephone only surveys. A review of volume data from surgery centers in Florida, Georgia and Tennessee suggests that the number of facilities in each of these states that would not meet the 938 patient volume threshold ranges from approximately 20 to 33 percent. Presumably some of these small centers (those that see at least 750 patients each year) would then need to default to the more expensive mail and telephone mixed mode. For the remainder having a patient volume too small to yield 300 completed surveys per year, CMS says, “a census will be surveyed”, presumably meaning that centers with low volumes would be expected to survey all their patients. The result is that the significant minority of ASCs with low patient volumes relative to the expectations laid out in this proposed data collection would face the steepest burdens associated with the use of the survey. These centers would be unlikely to participate voluntarily.

Though we recognize the statistical trade-offs inherent in a smaller number of completed surveys, we believe a goal of 100 completed surveys each year is most appropriate to the ASC industry as a whole and is a more even-handed way of balancing the Federal government’s desire for data with the burdens on the providers who must finance its collection.

D. The Length of the OAS CAHPS Imposes Undue Burden

In our previous comments, the ASC QC has urged tightly limiting the number of items included in the survey to ensure high response rates and to control the cost of administration. Despite the reduction of the number of items from the original 49 to current 37, the survey remains much too long.

We note that the Hospital CAHPS survey includes only 32 items. Given the potential complexity and length of patient stays at acute inpatient hospitals, it is difficult to reconcile the idea that an even longer survey is appropriate to the ASC setting, where patients are being seen for elective surgery and have stays of less than 24 hours. Reason would dictate that the length of the ASC survey would be no longer than the hospital survey, and common sense would say it should be shorter.

Our collective, real-world experience has repeatedly shown that brief surveys have a better response rate in the ambulatory surgical patient population. Through trial and error, ASC management companies have learned to keep their patient experience surveys short in order maximize patient response rates and to minimize cost. We urge you to seriously consider this hard-earned experience, and to take immediate steps to remove additional items from the survey. In particular we draw your attention to the inclusion of items that are not actionable (items 16, 18, 20, and 22), the inclusion of a question regarding a requirement under the ASC Conditions for Coverage (item 13), and the inclusion of optional items in the patient demographic questions
(items 26, 34, 35, and 37). For specific, detailed suggestions on how to shorten the survey, please see our most recent comments, which are attached in Appendix B.

Many ASCs solicit feedback from all patients seen because they believe every patient should have the opportunity to provide feedback regarding their experience. The substantial burdens associated with this survey make it highly unlikely any ASC could afford to survey all patients using this instrument. In order to continue to survey all patients with focused and actionable questions, these ASCs would have to consider fielding two surveys: 1) their current brief, timely and actionable instrument and 2) the OAS CAHPS to the mandated sample (a duplication of effort).

II. Estimated Burden for the National Implementation of OAS CAHPS is Inaccurate and Steps Have Not Been Taken to Reduce Burden for Small Entities

Estimates of annualized burden hours and costs for the national implementation of OAS CAHPS are presented in the OMB Supporting Statement that accompanies the survey. These include estimates of the costs to facilities to prepare and submit files of patient data to survey vendors over the course of a year. These estimates appear to be based on conjecture that was not confirmed in an actual ASC, and are not accurate.

CMS states it “believes that the 34 hours of labor that the HOPD/ASC will need to do annually can be conducted by a Database Administrator.” The typical ASC does not employ a Database Administrator. As we noted above, ASCs are predominantly small businesses. The majority (63%) of centers have 20 or fewer full-time equivalents, including both clinical and non-clinical staff (Ambulatory Surgery Center Association’s 2012 ASC Salary & Benefits Survey). A specialized position like a Database Administrator is not feasible within such a small staff. The responsibility for preparing and submitting patient data files (which, in this case, would include not only personally identifiable information, but also protected health information) to a survey vendor is most likely to fall to the facility’s Business Office Manager. Pay rates for ASC Business Office Managers are significantly higher than those for a Database Administrator. Further, ASCs will have to contract with a third-party to write the subroutine to create a report extracting the needed data from the ASC’s billing system. Hiring an external contractor for this purpose is likely to cost approximately $5,000 with an annual ongoing support fee of $1,000 (20 percent of the initial report cost).

The Supporting Statement also asserts, “[t]he survey should not impact small businesses or other small entities.” This statement appears to indicate the agency only considered the survey respondents, without regard for the ASCs who will be responsible for paying for the survey’s administration. Consequently, the Supporting Statement fails to meet Federal requirements for addressing burden reduction for small entities because the impact on ASCs as small businesses was not even considered.

III. Ways to Enhance the Utility of the OAS CAHPS

Many facilities currently include an open-ended question that provides patients an opportunity to share written comments regarding their experience. These comments are typically
very valuable and actionable. The absence of this opportunity in the current survey format is frustrating, and means that ASCs will have to bear additional expense to include this opportunity for patient input.

Patient safety is an important topic, and certain accreditors require it be addressed in an ASC patient experience survey. The absence of a question of this type is a significant oversight, and means ASCs would have to add such a question to the survey to make it adequate to their needs. We again request that a question for this topic be included in lieu of other non-essential items. Suggestions for a suitable safety item are included in our previous comments on this survey, which are attached for your convenience.

Finally, many ASCs treat pediatric patients. We remain disappointed to see the pediatric age range has still not been included in the response options for item 27 regarding patient age. This omission will significantly limit the utility of this survey instrument. We again urge the inclusion of the pediatric age group in the response options until such time as a separate pediatric instrument is developed. This would allow an important opportunity for input from pediatric patients and their parent(s) or guardian(s). The option for a proxy respondent has already been incorporated into the survey in item 36, so the change would be a minor one.

Participating facilities are expected to bear the cost of the national implementation of this survey instrument. Unfortunately, they will find themselves paying for an overly long survey that fails to meet their basic requirements for patient experience information, and then having to pay more to fill the gap of unmet needs. While the participation is characterized as voluntary, CMS has already taken the initial steps toward the inclusion of quality measures related to this instrument in the ASC Quality Reporting Program (also a “voluntary” activity that involves forfeiture of payments for non-participation).

IV. Summary of Critical Issues and Key Concerns Regarding the Survey

The ASC QC would like to promote the highest possible levels of ASC usage of the OAS CAHPS. The following is a summary of critical issues and key concerns that must be addressed to alleviate burden and improve the instrument.

- The lack of use of information technology is a hindrance and increases burden unnecessarily.
- CMS should expand, rather than contract, survey administration options to keep provider costs at a minimum and to enhance the ability to collect more timely and accurate patient responses.
- The expected number of completed surveys must be equitable.
- The survey must be significantly shortened, focusing sharply on critical, actionable aspects of patient experience and essential demographic data.
- The cost estimates are understated and must be corrected.
- The survey should be revised to incorporate opportunity for patient comment, an item regarding patient safety, and an opportunity to evaluate pediatric patient experience.
In summary, we would like to reiterate our appreciation of CMS for leading the development of this important patient experience survey for ASC and HOSD use. We urge OIRA to take definitive steps to address our ongoing concerns. We would be happy to assist with questions or provide additional information at your request.

Sincerely,

Donna Slosburg, BSN, LHRM, CASC
Executive Director, ASC Quality Collaboration
727-367-0072
donnaslosburg@ascquality.org
Appendix A
Current Participants in the Activities of the ASC Quality Collaboration

Accreditation Association for Ambulatory Health Care
Ambulatory Surgery Foundation
Ambulatory Surgical Centers of America
American College of Surgeons
American Osteopathic Association, Healthcare Facilities Accreditation Program
AmSurg
ASD Management
Association of periOperative Registered Nurses
Covenant Surgical Partners
Florida Society of Ambulatory Surgical Centers
Hospital Corporation of America, Ambulatory Surgery Division
Outpatient Ophthalmic Surgery Society
Regent Surgical Health
Surgery Partners
Surgical Care Affiliates
The Joint Commission
United Surgical Partners International
Visionary Enterprises, Inc.
Appendix B

ASC Quality Collaboration Comment Letter
Regarding Document Identifier CMS-10500;
Outpatient/Ambulatory Surgery Patient Experience of Care Survey (O/ASPECS):
Response to Notice at 80 FR 2430

Submitted March 17, 2015
March 17, 2015

VIA ELECTRONIC SUBMISSION

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier CMS-10500
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Document Identifier CMS-10500; Outpatient/Ambulatory Surgery Patient Experience of Care Survey (O/ASPECS)

Dear Acting Administrator Slavitt:

On behalf of the ASC Quality Collaboration (ASC QC), a cooperative effort of organizations and companies interested in ensuring ambulatory surgical center (ASC) quality data is appropriately developed and reported, please accept the following comments regarding Document Identifier CMS-10500, also known as Outpatient/Ambulatory Surgery Patient Experience of Care Survey (O/ASPECS) (80 FR 2430). The ASC QC’s stakeholders include ASC corporations, ASC industry associations, physician and nursing professional societies, and accrediting bodies with an interest in ASCs. Please see Appendix A for a list of the ASC QC’s participating organizations.

The ASC QC strongly advocates quality reporting. This commitment is reflected in the steps we have taken independently to facilitate quality reporting by ASCs – all without federal incentive or penalty. This includes developing ASC facility-level quality measures, as well as developing and publishing a quarterly public report of ASC quality data that is freely available online. These quarterly reports are made possible through the voluntary efforts of participants in the ASC QC and may be accessed at the ASC QC’s website.

We have had a longstanding interest in the development of a patient experience survey for outpatient surgical facilities similar to CAHPS® survey tools currently in existence for other providers. We fully support the development of a standardized survey instrument focusing on the care provided by the facility. We are pleased the O/ASPECS addresses the experience of surgical care received in both hospital-based outpatient surgical departments (HOSDs) and ASCs, increasing opportunities for consumers to make meaningful comparisons across outpatient
surgical facility settings. CMS and the ASC QC have a shared goal of fostering the highest possible levels of voluntary ASC use of the survey instrument.

In this Notice, CMS is requesting "comments regarding our burden estimates or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency’s functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden."

We appreciate all the work CMS and its contractor, RTI, have invested in creating the version of the O/ASPECS that is associated with this Notice. Tremendous progress has been made, and with additional improvements the instrument has the potential to fill a gap in standardized quality measurement for the ASC and HOSD settings. The following comments reflect the specific, detailed observations and suggestions for improvement offered by the ASC QC’s Technical Expert Committee, many of whom - in addition to their clinical and other expertise – have worked directly in the fielding and analysis of patient experience surveys by their respective organizations. We hope the agency will duly consider the depth of our collective expertise in the ASC industry when determining the merit of our feedback.

A. The Length of the O/ASPECS Results in Undue Burden

In our March 2013 response to CMS-4171-NC (the Request for Information for this project) and again in our December 2013 comments regarding CMS-10500, the ASC QC urged the agency to tightly restrict the number of items in the survey to ensure high response rates and to control cost. While we are pleased to see that the number of items has been reduced from 49 to 37, the current survey remains much too long.

As stated in our comments to CMS on March 2013, keeping the administrative and financial burden of administering this survey as low as possible is imperative. ASCs are predominantly small providers – according to CMS estimates, approximately 73 percent of ASCs would be classified as small businesses according to the Small Business Administration size standards [72 Fed. Reg. 66901]. The predominance of small facilities is corroborated by CMS data that indicates a median of two operating/procedure rooms per facility (mean = 2.5). Further, the ASC Association’s 2012 ASC Salary & Benefits Survey shows the majority (63%) of ASCs have 20 or fewer total full-time equivalents, including both clinical and non-clinical staff. If the survey is unduly expensive and resource-intensive compared to their current process for evaluating patient experience (the ASC Association’s Outcomes Monitoring Project, fielded quarterly, typically finds that virtually all participating ASCs - over 99 percent of respondents - use a patient survey), ASCs may forego use of the O/ASPECS.

Our real-world collective experience has repeatedly shown that brief surveys have a better response rate in the ambulatory surgical patient population. Through trial and error, our management companies have learned to keep ASC patient experience surveys short in order to both manage cost and maximize patient feedback. We urge CMS to seriously consider this hard-
earned experience, and to take immediate steps to remove additional items from the survey.

We see several items in the survey that are good candidates for removal. The first is item 13: “Discharge instructions include things like symptoms you should watch for after your procedure, instructions about medicines, and home care. Before you left the facility, did you receive written discharge instructions?” As we have pointed out in previous comments, written discharge instructions are required by the ASC Conditions for Coverage at §416.52(c)(1), which state that “[e]ach patient, or the adult who accompanies the patient upon discharge, must be provided with written discharge instructions.” There is little to be gained from including this question in the survey.

We also see an opportunity for consolidation in the section titled “Your Recovery”. Items 15, 17, 19 and 21 ask whether the patient received information about what to do regarding pain control, nausea or vomiting, bleeding, or signs of infection. While these topics reflect some of the problems that can arise after procedural services, they are not tailored to the patient but rather to a generic list of outcomes. What about, for example, the cataract surgery patient for whom blurry vision would be an important problem? Or the patient undergoing a urinary procedure, for whom inability to void would be a key issue? In effect, the survey has decided what the focus of patient discharge information should be for every patient, completely disregarding the principle of patient-centeredness and also ignoring important procedure-specific concerns.

Since it is not feasible to address every important problem that might arise after discharge in a general survey, a single item that addresses the topic at the core of each of these questions - the patient’s need for information about what to do in the event a problem arises after their procedure - should be substituted for items 15, 17, 19, and 21. The topic is most efficiently addressed with a question such as, “Before you left, did your doctor or anyone from the facility give you information about what to do if you had problems as a result of your procedure or the anesthesia?” This consolidation would help reduce the length of the survey.

In addition, we note that several of the items in this section of the survey have little utility. These include items 16 (At any time after leaving the facility, did you have pain as a result of your procedure?), 18 (At any time after leaving the facility, did you have nausea or vomiting as a result of either your procedure or the anesthesia?), 20 (At any time after leaving the facility, did you have bleeding as a result of your procedure?), and 22 (At any time after leaving the facility, did you have any signs of infection?). The patient’s responses to these items cannot be used to improve performance without other relevant clinical information. As CMS is aware, ASCs offer a broad range of surgical services across many subspecialties, from which a very broad range of outcomes is possible. Items 16, 18, 20 and 22 ask the patient if they experienced selected potential post-procedure signs and symptoms. If a patient reports pain following their procedure on the survey, how is the ASC to determine whether pain was an expected or unexpected outcome for that patient? If the patient reports nausea or vomiting, how is the ASC to determine if it was related to the procedure, the anesthesia, or perhaps a medication prescribed for pain management? If the patient reports bleeding, how does the ASC determine if this was expected (bloody nasal discharge after sinus surgery, bloody urine after urinary tract surgery) or unexpected? If the patient reports “signs of infection”, how is the ASC to determine if the patient’s affirmative response is an indication of an actual infection, or of something that
does not require action - like erythema at the wound margin? In the absence of other key information, the survey results for these items are not actionable.

We believe that CMS has already recognized this problem, as the agency has not opted to include these items in the measures it is already in the process of developing that are based on this survey. (Please see the survey-related measures X3697, X3698, X3699, X3702 and X3703 that CMS included on the Measures Under Consideration List presented to the Measure Applications Partnership for review late last year.) Given their lack of utility and the lack of any plans to use these patient responses in future performance measurement activities, these questions should be deleted.

Finally, we continue to believe that the number of items in the “About You” section of the survey needs to be addressed. In our view, the inclusion of 13 demographic questions in this section is excessive. Only those items that are required by law or that would actually be used in patient-mix adjustment for public reporting purposes should be included. Based on our review of the factors used in the patient-mix adjustment for other CAHPS® surveys, only the items that identify self-reported health status (item 25), age (item 27), education (item 29), primary language other than English (item 33) and a proxy respondent (item 36) should be retained. Federal data collection requirements regarding sex, race, ethnicity, and primary language can be met with items 28, 30, 31, 32 and 33. The other four items (26, 34, 35 and 37) are not essential. In fact, the US Office of Minority Health clearly identifies items 34 and 35 as optional in its implementation guidance. It is not reasonable to ask ASCs to shoulder the additional cost of items that are optional. Optional and non-essential items in this category add burden and should be removed.

**B. Requiring the Use of a CMS-Approved Survey Vendor for Administration of the O/ASPECS Will Result in Undue Burden**

To encourage widespread use of the O/ASPECS, CMS must minimize provider cost. CMS should allow multiple survey administration options to ensure ASCs can choose the most affordable approach for their facility. This includes administration through a third-party vendor, self-administration for an individual facility, and self-administration for multiple facilities. Requiring the use of a CMS-approved survey vendor will be an additional and undue financial burden to many ASCs, who are already faced with a multitude of costly Federal requirements.

In addition, we strongly advocate an option to *distribute* the survey at the point of care upon the patient’s discharge from the ASC/HOSD in order to more promote timely and accurate responses. The process CMS has outlined in this Notice is likely to result in patients receiving their survey roughly one to two months following the date of service. We are concerned that this delay will negatively affect the patient’s ability to accurately recall all that happened during their visit. The details of the education and explanations received not only at the time of service, but in advance of their visit during the pre-operative visit to their surgeon or the pre-operative phone call from the facility may become more difficult to recollect after such a long period of time.

We also favor the option to distribute the survey at the time of discharge in order to control costs. It is commonplace for an ASC to give their current survey instrument to the
patient while they are on site, with instructions to complete the survey after discharge. This practice helps reduce the cost per returned survey. We anticipate the cost of having a vendor distribute the surveys will substantially increase the cost per returned survey. Distribution at the point of care also gives facilities the flexibility they need to modify the survey on an as-needed basis to address their individual performance improvement objectives.

We do not recommend on-site administration of the survey to the patient for a number of reasons, including the introduction of bias, the potential impact of recent sedation or anesthesia, and insufficient time having elapsed for the patient’s assessment of self-reported outcomes.

C. Estimated Burden for the National Implementation of O/ASPECS is Inaccurate and Incomplete

Estimates of annualized burden hours and costs for the national implementation of O/ASPECS are presented in the OMB Supporting Statement that accompanies the survey. These estimates include hours spent and associated costs for the survey respondent (the patient or their proxy). They also include estimates of the costs to facilities to prepare and submit files of patient data to survey vendors over the course of a year. We have reviewed these estimates and find them both inaccurate and incomplete.

CMS states, “[t]he survey should not impact small businesses or other small entities.” In making this assertion, the agency appears to have only considered the survey respondents without regard for the ASCs who will be involved. As the agency itself has stated elsewhere (see 72 Fed. Reg. 66901) and as we noted above, ASCs are predominantly small businesses - approximately 73 percent of ASCs would be classified as small businesses according to the Small Business Administration size standards. The survey will clearly have an impact on small entities, and this needs to be addressed appropriately.

CMS also states it “believes that the 34 hours of labor that the HOPD/ASC will need to do annually can be conducted by a Database Administrator.” We cannot speak for the HOPD setting, but the typical ASC does not employ a Database Administrator. As we noted above, ASCs are predominantly small businesses, and the majority have 20 or fewer full-time equivalents, including both clinical and non-clinical staff. The responsibility for preparing and submitting patient data files (which, in this case, would include not only personally identifiable information, but also protected health information) to a survey vendor is most likely to fall to the facility’s Business Office Manager. Pay rates for ASC Business Office Managers are significantly higher than those for a Database Administrator. Further, ASCs will have to contract with a third-party to write the subroutine to create a report extracting the needed data from the ASC’s billing system. Hiring an external contractor for this purpose is likely to cost a minimum of $5,000 with an annual ongoing support fee of $1,000 (20 percent of the initial report cost).

In addition, we note that the estimates presented do not include the cost the ASC would have to bear in order to contract with a CMS-approved survey vendor. Such contracts result in many thousands of dollars of additional expense for each facility. Although these expenses would represent the most significant portion of the burden associated with the use of this survey, they are not even considered in this Notice.
D. Use of Information Technology to Minimize Burden

This Notice specifically requests public comment on the use of information technology to minimize the information collection burden associated with the O/ASPECS. As stated in our comments to CMS on March 25, 2013 in response to the CMS-4171-NC and again in our December 2013 comments regarding CMS-10500, information technology should be used to the fullest extent possible to keep burden low.

Two information technology solutions should be implemented in order to minimize information collection burden: the use of electronic mail with mail or telephone as a mixed mode administration option, and the use of a web-based survey administration mode. Both information technology solutions are already in use in other patient experience surveys: the CAHPS® Surgical Care Survey may be administered using mixed modes involving electronic mail, and web-based patient surveys are already successfully used by many leading healthcare market research firms.

In the OMB Supporting Statement associated with this Notice, CMS states, “[a]ny additional forms of information technology, such as web surveys, would be less feasible with O/ASPECS patients, as patient e-mail address information is not readily available through HOPDs and ASCs.” This statement is clearly incorrect. Patient email addresses can be, and are, as readily collected as the patient’s address and phone number. It is unthinkable that, in this age of nearly ubiquitous information technology in daily life, CMS is not considering its use in developing the modes of administration for this survey.

In the past, CMS has expressed reluctance to offer these information technology solutions because of its impression that Medicare beneficiaries or poor households would be unlikely to respond online. However, data from other government agencies indicates that the use of enabling technology is not only prevalent, but also expanding rapidly amongst all Americans regardless of age, sex, educational attainment, household income, and employment status. We encourage the agency to review the most recent data from the US Census Bureau regarding Internet use, which is included in its dataset titled Computer and Internet Use in the United States: 2013, released in November 2014. (Note particularly that the number of individuals age 65 years and older living in a house with a computer has increased to 71.0 percent from 61.8 percent just two years earlier. Also of interest is that while in 2011 45.5 percent of individuals age 65 and older accessed the Internet from some location, the number living in a house with Internet use had grown to 64.3 percent in 2013.) The National Telecommunications & Information Administration of the US Department of Commerce has recently issued two pertinent items pointing to significant growth in the use of the Internet over time in all age groups. Both, Exploring the Digital Nation: America’s Emerging Online Experience and Exploring the Digital Nation: Embracing the Mobile Internet, are available online. The latter report states, “some form of broadband, whether fixed or mobile, is now available to almost 99 percent of the U.S. population” [emphasis added].

It is vital that steps be taken at this important juncture to ensure information technology becomes incorporated in the modes of administration of the O/ASPECS survey. The agency must
move to ensure its patient experience data collections remain relevant and useful in the context of modern society. At this point in the nation’s history it would be neglectful to fail to incorporate electronic mail and a web-based survey in the mode experiment and subsequent national implementation.

E. Ways to Enhance the Utility of the O/ASPECS

Many ASCs solicit feedback from all patients because they believe every patient should have the opportunity to provide feedback regarding their experience. The substantial burdens associated with this survey make it highly unlikely any ASC could afford to survey all patients using this instrument. In order to continue to survey all patients with focused and actionable questions, these ASCs would have to consider fielding two surveys: 1) their current brief, timely and actionable instrument and 2) the O/ASPECS to the mandated sample (a duplication of effort).

Many facilities currently include an open-ended question that provides patients an opportunity to share written comments regarding their experience. These comments are typically very valuable and actionable. The absence of this opportunity in the current survey format is frustrating, and means that ASCs will have to bear additional expense to include this opportunity for patient input.

Patient safety is an important topic area, and one that certain accreditors require be addressed in an ASC patient experience survey. The absence of a question of this type is a significant oversight. ASCs would have to add such a question to the survey to make it suitable for their use. As we have done in our previous communications on this survey, we again request that a question for this topic be included in lieu of other non-essential items. The question should touch on recognized guidelines for safe care that: 1) are likely to be universal across the spectrum of patient experience in ASCs/HOSDs, 2) directly involve the patient, and 3) are likely to be remembered because they involve a verbal response from the patient or direct caregiver contact with the patient. Potential topics include: 1) whether the medical staff washed their hands before each patient contact, 2) whether the surgical site or procedure was confirmed with the patient, or 3) whether personnel checked the patient’s identification before giving a medication.

Finally, many ASCs treat pediatric patients, so we remain disappointed to see the pediatric age range has still not been included in the response options for item 27 regarding patient age. This omission will significantly limit the utility of this survey instrument. Therefore, we again urge the agency to include the pediatric age group in the response options until such time as a separate pediatric instrument is developed. This would allow an important opportunity for input from pediatric patients and their parent(s) or guardian(s). The option for a proxy respondent has already been incorporated into the survey in item 36, so the change would be a minor one.

In short, this project has not given adequate consideration to the provider. The facility must bear all the burdens associated with using the instrument. Unfortunately, they will find themselves paying for a survey that fails to meet their needs, and then having to pay more to fill the gap of unmet needs.
F. Summary of Critical Issues and Key Concerns Regarding the Survey

As noted above, CMS and the ASC QC have a shared goal of fostering the highest possible levels of ASC usage for the O/ASPECS. The following is a summary of critical issues and key concerns that must be addressed to alleviate burden, improve the instrument, and achieve the stated project goals.

- The survey must be significantly shortened, focusing sharply on critical, actionable aspects of patient experience and essential demographic data.
- The cost burdens are significantly understated and must be corrected.
- The lack of use of information technology is a hindrance and increases burden unnecessarily.
- CMS should expand, rather than contract, survey administration options to keep provider costs at a minimum and to enhance the ability to collect more timely and accurate patient responses.
- The survey should be revised to incorporate opportunity for patient comment, an item regarding patient safety, and an opportunity to evaluate pediatric patient experience.

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In summary, we again wish to express our appreciation to CMS for taking the lead in the development of this important patient experience survey for ASC and HOSD use. We hope the agency will take definitive steps to address our ongoing concerns. We would be happy to assist with questions or provide additional information at your request.

Sincerely,

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Appendix A
Current Participants in the Activities of the ASC Quality Collaboration

Accreditation Association for Ambulatory Health Care
Ambulatory Surgery Foundation
Ambulatory Surgical Centers of America
American College of Surgeons
American Osteopathic Association, Healthcare Facilities Accreditation Program
AmSurg
ASD Management
Association of periOperative Registered Nurses
Covenant Surgical Partners
Florida Society of Ambulatory Surgical Centers
Hospital Corporation of America, Ambulatory Surgery Division
Outpatient Ophthalmic Surgery Society
Regent Surgical Health
Surgery Partners
Surgical Care Affiliates
The Joint Commission
United Surgical Partners International
Visionary Enterprises, Inc.