



ASC Quality Collaboration

June 9, 2017

Thomas E. Price, M.D., Secretary
US Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: The Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey

Dear Dr. Price and Ms. Verma:

The ASC Quality Collaboration (ASC QC) is a non-profit organization dedicated to advancing quality measurement and public reporting in the ambulatory surgery center (ASC) industry through a collaborative effort involving a diverse group of ASC stakeholders. These stakeholders include leaders from the ASC industry, accreditation organizations, and professional associations (please find a list of these stakeholders in Appendix A to this letter). Collectively these organizations represent over 1,500 ASCs.

We are writing to you regarding the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey. The ASC QC actively supported the development of the OAS CAHPS by participating on the project Technical Expert Panel, assisting with the recruitment of centers for pilot testing, and repeatedly sharing detailed written feedback on the instrument at every opportunity presented by CMS and the Office of Management and Budget (OMB) under the previous Administration. We welcome a standardized survey that addresses patient experience in both hospital-based outpatient surgical departments and ASCs, but believe changes to the current OAS CAHPS Survey and the CMS policies regarding its use are urgently needed. This Administration is clearly serious about regulatory reform where undue burden exists. Confident that you will take action, we bring the following items to your attention:

- CMS and OMB have significantly understated the survey costs to be borne by ASCs.
- The survey is too long and must be significantly shortened, focusing sharply on critical, actionable aspects of patient experience and essential demographic data.
- The survey modes do not take advantage of information technology, increasing costs unnecessarily.
- On-site survey distribution should be permitted to help keep provider costs as low as possible and also to enhance the collection of more timely (and therefore accurate) patient responses.

- The minimum number of surveys is too high and affects low volume ASCs disproportionately.
- The survey results should be publicly reported in a way that allows consumers to tie information directly to an individual facility.

These matters are pressing because CMS plans to use OAS CAHPS Survey data as the basis for five quality measures in its Ambulatory Surgical Center Quality Reporting Program (ASCQR Program) beginning with the CY 2020 payment determination. Therefore ASCs must be prepared to implement the survey beginning with January 2018 dates of service. However, making much-needed changes to the OAS CAHPS will take time and is unlikely to be accomplished by January 2018. *The ASC QC therefore urges the Secretary and CMS to delay the implementation of the five OAS CAHPS survey-based measures* until these issues have been satisfactorily addressed.* In the interim and until such time as needed revisions to the survey itself and related CMS policies are in place, we support continued voluntary use of the OAS CAHPS Survey.

In the pages that follow we offer detailed input regarding the issues identified above. All recommendations reflect two goals, namely ensuring the OAS CAHPS is as useful to consumers and as affordable to ASCs as possible.

A. Recognize the Importance of Controlling Cost

Attention to cost is paramount to maximizing use of the OAS CAHPS. The costs of administering the survey will be borne by the surgical facility, and the current instrument and CMS policies make the survey more expensive than necessary.

CMS has stated, “[t]he survey should not impact small businesses or other small entities.” In making this assertion, the agency completely forgot the ASCs who must pay for the survey. As CMS has acknowledged elsewhere, ASCs are primarily small providers; the agency has stated approximately 73 percent of ASCs would be classified as small businesses according to the Small Business Administration size standards [see 72 Fed. Reg. 66901]. The predominance of small facilities is confirmed by CMS data indicating 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. Finally, ASCs are very cost sensitive due to lower reimbursement compared to other facilities providing outpatient surgical services. As recently as 2003, Medicare paid ASCs 86% of the amount paid to Hospital Outpatient Departments (HOPDs); now Medicare pays ASCs 49% of the amount paid to HOPDs. Given the above ASC characteristics, it is imperative to keep the administrative and financial burden associated with this survey as low as possible.

CMS has also stated 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

*ASC-15a: OAS CAHPS – About Facilities and Staff; ASC-15b: OAS CAHPS – Communication About Procedure; ASC-15c: OAS CAHPS – Preparation for Discharge and Recovery; ASC-15d: OAS CAHPS – Overall Rating of Facility; and ASC-15e: OAS CAHPS – Recommendation of Facility.

employ a Database Administrator. As noted above, the majority of ASCs have 20 or fewer full-time equivalents, including both clinical and non-clinical staff. The responsibility for preparing and submitting patient data files (which would include both personally identifiable information and protected health information) to a survey vendor is 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.

In addition, the estimates do not include the cost of contracting 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 the OAS CAHPS, they have not been considered.

Several ASC QC members have taken steps toward using the OAS CAHPS survey voluntarily and have encountered additional unanticipated costs. The first of these is making provision for the patient populations excluded from the measure, namely patients who cannot be surveyed because of state regulations, patients whose address is not a U.S. domestic address, patients who request that the ASC not release their name and contact information to anyone other than facility personnel ("no-publicity" patients), prisoners, nursing home residents, patients discharged to hospice, and deceased patients. Presently, the ASC billing systems that would be used to develop the files of eligible patient data are not capable of identifying these patient populations. Adding this capability to the functionality of those systems is proving complicated, time-consuming and costly. In addition, ASCs must pay for the creation of an electronic interface between their billing systems and their survey vendor to communicate patient information. There is significant cost – thousands of dollars of additional charges – associated with these steps in implementation. Many ASCs will find these issues very challenging, time-consuming, and expensive to address.

In short, many ASCs will find the costs of implementing the OAS CAHPS survey greater than the 2% payment update penalty for failing to meet ASCQR Program requirements. In the face of this, some ASCs may choose to forgo use of the survey. Even worse, those that choose to sit out the survey will undoubtedly realize this will result in a payment penalty even if they submit all other required data, and could decide to forgo participation in the ASCQR Program entirely. This would be unfortunate, and therefore we encourage you to make changes to rein in the mounting costs of participation.

B. Shorten the OAS CAHPS Without Sacrificing Essential Information

To gain perspective, consider that the Hospital CAHPS survey includes 32 items, while the OAS CAHPS has 37. Given the potential complexity and length of patient stays at acute inpatient hospitals, it is difficult to reconcile the idea that a longer survey is appropriate to the ASC setting, where patients are seen for elective surgery and have stays of less than 24 hours. CMS should take advantage of all opportunities to carefully focus the OAS CAHPS to achieve a balance that maximizes the utility of the patient experience data while minimizing the burdens of data collection. The real-world experience of our member organizations has repeatedly shown that brief surveys have a better response rate; ASC management companies keep surveys short to manage cost and maximize patient feedback.

CMS should take immediate steps to shorten the survey. As we discuss in detail below, several items in the survey are good candidates for removal or consolidation.

1. Recommendation Regarding “Communications About Your Procedure”

According to Agency for Healthcare Research and Quality (AHRQ), the first principle of CAHPS survey design is that these surveys should ask about aspects of care “for which the patient is the best or only source” (see the relevant AHRQ archives from their 2012 annual meeting). Knowing this, it is unclear why the OAS CAHPS survey includes the following item: “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?” It is a reasonable question, but the patient is not the only source of information regarding this practice.

As you know, ASCs are subject to the standards laid out in the CMS ASC Conditions for Coverage, which must be met in order to participate in the Medicare and Medicaid programs. Compliance with these federally mandated requirements is assured by individual State Survey Agencies, which inspect ASCs to ensure the standards are being met and that facilities are qualified to participate. Written discharge instructions are required by the ASC Conditions for Coverage at §416.52(c)(1), which states “[e]ach patient, or the adult who accompanies the patient upon discharge, must be provided with written discharge instructions.” A similar requirement is in place for HOPDs.

There is no need to duplicate effort around this requirement by including a question regarding this standard practice in the OAS CAHPS as well. Given that the patient is not the only source of information about this practice, this question (item 13) adds cost without adding new information, and should be removed.

2. Recommendations Regarding “Your Recovery”

There is an excellent 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 ASC services, they are not tailored to the patient but rather to a generic list of outcomes that may or may not be pertinent to the patient’s experience. In effect, those who designed the survey decided what the focus of patient discharge information should be for every patient, completely disregarding important procedure-specific concerns (and the oft-repeated tenet of patient-centeredness). For example, cataract surgery is the most commonly performed procedure in ASCs; for this surgery worsening vision would be a top concern. For other patients, inability to void would be a key issue.

In truth, it is not feasible to address every significant sign or symptom that might indicate a complication after discharge in this survey. However, it is possible to pose a single question that addresses the topic at the core of each of these items - the patient’s need for information about what to do in the event a problem arises after their procedure. 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?” would efficiently and effectively

address this important issue. Consolidating items 15, 17, 19 and 21 into a single question is a win-win proposition: it would reduce the length of the survey without sacrificing essential feedback regarding a key aspect of patient experience.

The “Your Recovery” section of the survey also features several questions that have no practical utility. Specifically, the patient’s responses to 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?) *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 focus on a very limited set of potential post-procedure signs and symptoms, but the responses do not provide any of the context necessary for quality assessment or improvement. If a patient reports pain following their procedure on the survey, the ASC *cannot determine* whether that pain was an expected outcome (such as pain following arthroscopic surgery) or unexpected outcome (ocular pain following cataract surgery or abdominal pain following gastrointestinal endoscopy) for that patient. If the patient reports nausea or vomiting, the ASC *cannot determine* if it was related to the procedure, the anesthesia, or a medication prescribed for pain management. If the patient reports bleeding, the ASC *cannot determine* if this was expected (bloody nasal discharge after sinus surgery or bloody urine after urinary tract surgery) or unexpected (bleeding from an incisional site). If the patient reports “signs of infection”, the ASC *cannot determine* if the patient’s affirmative response is an indication of an actual surgical site infection, or of something that does not require action, like isolated erythema at the wound margin. It *does not make sense* to consume resources collecting this information when the data is not actionable.

Further, CMS has characterized these questions as “control questions” that “would not impact provider scores on the OAS CAHPS survey questions” (see 81 FR 79816). In its remarks regarding the control questions, CMS states the following:

“... the focus of Questions 15 and 16 is to determine whether a patient who is expected to experience pain as a result of a procedure was given information from the doctor or anyone from the facility about what to do about pain. If a patient experiences pain as a result of a procedure (Question 16), it is important that the patient was provided information as to what to do about the pain (Question 15). In these instances, the response to Question 15 would be included in the score. However, for some procedures conducted in an ASC (for example colonoscopies), there is little expectation of the patient experiencing pain. *In these instances, a doctor or anyone from the facility may not have given a patient information about what to do about pain as such information would not be relevant* [emphasis added]. In these latter instances, the response to Question 15 would not be included in the score unless the patient response is a top-box (that is, “Yes, definitely”) response.”

This response, particularly the portion we have italicized, indicates a state of confusion. It is true that patients undergoing colonoscopy are not expected to experience pain following their procedure; yet abdominal pain could be an indication of a serious complication (intestinal

perforation). It is standard of care to advise patients undergoing colonoscopy to seek medical attention if abdominal pain other than mild cramping occurs following their procedure. Just because a patient does not experience this pain is not a reason to think they should not have received information about what to do if it had occurred. In other words, the absence of the outcome *does not* mean that information about what to do if it occurred would not be relevant. The “control question” logic being applied is flawed. It only identifies the *small minority* of patients who experience a particular outcome and fails to fully address the true issue: whether each patient was informed of the potential post-discharge problems pertinent to their care. Again we come back to the point that what is actually relevant to an individual patient is determined by their unique situation and needs, and cannot be dictated by an arbitrary list of general outcomes. Please understand that we are not opposed to asking patients if they received the information they needed about what to do in the event of a problem following their care in the ASC. We think this is extremely important, and want to see the point addressed in a way that produces meaningful and actionable survey data. Consistent with our recommendation above, these “control questions” could be consolidated into a single item, such as “At any time after leaving the facility, did you have any problems as a result of the procedure or anesthesia?”.

Item 16 is also of concern because it is clearly focused on the experience of pain. In rulemaking elsewhere, CMS has determined it will remove the three pain management questions of the HCAHPS Survey from the total Hospital VBP Program performance score due to confusion about the intent of these questions and the public health concern about the ongoing prescription opioid overdose epidemic. The OAS CAHPS Survey contains two questions regarding pain management (items 15 and 16), which CMS has stated, “are very different from those contained in the HCAHPS Survey because they focus on communication regarding pain management rather than pain control.” However, item 16 is clearly focused on the experience of pain. Further, when placed in the context of other similar items in the survey, the question implicitly values a “No” response over a “Yes” response, implying patients should not experience pain after discharge. We understand that CMS views this as a “control question”, but the fact remains that the data for the question will be aggregated and analyzed by the survey vendor and provided to the facility, regardless of whether or not the question is used for the ASCQR Program measures. Healthcare providers are already under tremendous pressure to write prescriptions that appease patients in order to secure better patient reviews. CMS should not be applying fuel, directly or indirectly, to the fire of the epidemic.

3. Recommendations Regarding “About You”

Finally, the number of items in the “About You” section of the survey needs to be addressed. The inclusion of 13 demographic questions in this section is excessive. *Only 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, the only items needed for patient-mix adjustment are those 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). 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 must be removed.

C. Maximize the Use of Information Technology to Minimize Burden

Information technology should be employed to the fullest extent possible to keep survey data collection burden low. *In addition to the currently available survey modes, options that utilize information technology should be available, including the ability to send survey invitations via email as well as via text message (SMS), and the use of a web-based survey administration mode.* These solutions are already being used in other patient experience surveys both in this country and by other governments abroad. For example, 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 past CMS has stated, “[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. ASCs that do not routinely collect email addresses would certainly have an incentive to do so if the option to use them were available as a means to realize lower survey costs.

CMS has expressed reluctance to offer information technology solutions, believing Medicare beneficiaries or poor households would be unlikely to respond online. However, data from other US government agencies indicates the use of enabling technology is not only prevalent, but expanding rapidly amongst all Americans regardless of age, sex, educational attainment, household income, or employment status. We encourage CMS 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].”

Our members consistently report achieving significant cost savings by incorporating the use of electronic distribution of survey invitations 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. 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 OAS CAHPS survey administration. Failing to incorporate email and text message invitations and a web-based survey in the modes available *cannot be justified* in the light of current information technology adoption in the United States. Limiting survey administration options to mail, telephone and mixed mail/telephone leaves ASCs (and HOSDs) in the position of having to shoulder entirely avoidable costs.

D. Ease Burden by Allowing On-site Distribution of the OAS CAHPS

Surgical facilities should have the option to distribute the OAS CAHPS to all their patients at the time of discharge in order to control costs and improve results. It is commonplace for an ASC to give a survey to patients while they are on site, with instructions to complete the survey after discharge. This practice helps reduce the cost per returned survey. Requiring a vendor to distribute the surveys increases the cost per returned survey.

In addition, *distribution* at the point of care upon the patient's discharge from the ASC/HOSD would promote more timely and accurate responses. Currently, CMS policy calls for sampling on a monthly basis, which will result in patients receiving their survey roughly one to two months following the date of service. This delay will negatively impact the patient's ability to accurately recall 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 wish to be clear that we do not recommend *on-site administration* of the survey 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.

CMS has stated that it cannot offer this method of distribution because it was not tested. The agency made this choice despite input from affected stakeholders, who called upon CMS to include this option. We ask that you correct this by taking steps now to test distribution of the survey and/or a survey invitation at the point of care.

E. The Number of Required Surveys Affects Small ASCs Disproportionately

CMS has stated, “[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 sample size needed to assure 300 respondents using CMS's assumed response rate of 32% for mail only or telephone only surveys is 938 patients annually. A significant minority of ASCs treats less than 938 patients each year. A review of volume data from surgery centers in Florida, Georgia and Tennessee indicates approximately 20 to 33 percent of centers would not meet the threshold of 938 patients. Presumably some of these small centers would then be required to default to the more expensive mail and telephone mixed mode. ASCs whose patient volumes are too small to yield 300 completed surveys per year using the mixed mode would be

expected to survey all their patients. The result of these proposed policies is that a significant minority of ASCs – those with the lowest patient volumes - would face the steepest burdens associated with the use of the survey. This is inherently unfair.

CMS should immediately address the disproportionate survey costs low volume ASCs will face under current regulations. The agency should consider options, including lowering the minimum number of completed surveys and/or establishing a maximum percentage of annual patient visits. For example, a minimum of 200 completed surveys has been established for the In-Center Hemodialysis CAHPS Survey. The 300-survey threshold is also three times higher than that required during the initial years of survey implementation in other CMS programs. Originally, CMS set a threshold of 100 completed surveys for hospital participation in its HCAPHS Star Ratings initiative under the Hospital Inpatient Quality Reporting Program. The same standard was used in the Hospital Value-Based Purchasing Program.

F. Allow Consumers to Tie OAS CAHPS Survey Data to an Individual Facility

We advocate transparent and consumer-centric public reporting of quality measure data, including reporting data in a manner that allows the public to directly correlate quality measure data with an individual facility. Unfortunately, CMS has decided surgical facilities sharing the same CMS Certification Number (CCN) must combine data for the OAS CAHPS survey-based measures. These aggregated results would then be publicly reported on the Hospital Compare Web site “as if they apply to a single ASC.” The agency intends to note instances where publicly reported measures combine results from two or more ASCs “to increase transparency in public reporting and improve the usefulness of the Hospital Compare Web site.” While this may ostensibly improve the transparency of CMS policy, it would do nothing to increase the transparency of the combined data for the consumer, which is, after all, the point of this entire process. It’s plain that in cases where multiple facilities share the same CCN, combining results makes it impossible for consumers to understand the performance of the particular facility they may be interested in using. CMS should report quality measure data by National Provider Identifier (NPI) in order to fully support consumers in their decision-making regarding individual facilities.

CMS has stated the reason survey results will be collected and reported at the CCN level is because the OAS CAHPS Survey was tested at the CCN level. Since it will be necessary to conduct additional testing of the Survey as part of addressing needed changes to the survey content and modes of administration, it will be possible for CMS to conduct testing of NPI level data collection as well.

As you are likely aware, ASCs report ASCQR Program quality measure data to CMS using their NPI for all currently implemented measures *except* ASC-8, Influenza Vaccination Coverage among Healthcare Personnel. The Centers for Disease Control and Prevention (CDC), which collects the data for this measure through the agency’s National Healthcare Safety Network (NHSN), has indicated its willingness to consider changing from a CCN-based approach to an NPI-based approach. Making this change now would be particularly beneficial because NHSN is the likely data collection vehicle for a prospective, and important, ASC surgical site infection measure. CMS should work quickly with CDC to implement data collection under the NPI in NHSN, and plan to report all future measures by NPI.

G. Action Is Needed To Remove Obstacles

The ASC QC would like to see the highest possible levels of ASC usage for the OAS CAHPS Survey. However, several aspects of this survey – its excessive length, its limited modes of administration, the absence of an option to distribute the survey at the point of care, the expectations regarding the number of completed surveys, the issues with CCN level reporting, and the implementation costs to be borne – are problematic. They represent obstacles to maximizing the use (and usefulness) of the survey, and although most can be rectified, to date the agency has remained steadfastly bound to old and established approaches rather than embracing new, win-win efficiencies.

Under the previous Administration, CMS failed to give any serious consideration to the cost-saving and burden-reducing recommendations of affected stakeholders during the development of the survey. By failing to test options that could have significantly helped the provider community cope with the administrative and financial burden of the survey, the agency will place many in the ASC community in the position of having to decide if this is a tipping point. As we stated above, *many ASCs will find the costs of the OAS CAHPS survey greater than the 2% payment update penalty for failing to meet ASCQR Program requirements. As a result, they may choose to forgo use of the survey, and possibly forgo participation in the entire Program.*

It is not too late to salvage the situation. *We urge you to delay implementation of the OAS CAHPS survey measures while taking immediate steps to revise the survey and test more affordable survey administration options.* During this period of time, we support the continued voluntary use of the survey.

We wish to express our appreciation to CMS for taking the lead in the development of the OAS CAHPS. We hope that under this Administration, the agency will take prompt and definitive steps to address the urgent need for refinement.

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
AmSurg
ASD Management
Association of periOperative Registered Nurses
Covenant Surgical Partners
Florida Society of Ambulatory Surgical Centers
Hospital Corporation of America, Ambulatory Surgery Division
Merritt Healthcare
Outpatient Ophthalmic Surgery Society
Physicians Endoscopy
Practice Partners in Healthcare, Inc.
Regent Surgical Health
Surgery Partners
Surgical Care Affiliates
The Joint Commission
United Surgical Partners International
Visionary Enterprises, Inc.