ASC Quality Collaboration

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 it 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 additional 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.