

**Response to Comments Submitted Regarding CMS-10500, 60 Day Notice  
Outpatient and Ambulatory Surgery Patient Experience of Care Survey (O/ASPECS), now  
known as Outpatient and Ambulatory Surgery CAHPS (OAS CAHPS)**

Thank you for the opportunity to respond to comments submitted on response to the 60 Day Notice for CMS-10500, Outpatient and Ambulatory Surgery Patient Experience of Care Survey, which was posted on January 16, 2015. We value the commenters' careful and thoughtful review and feedback. Please note that the survey has recently been approved to use the CAHPS® trademark and the survey name has changed to Outpatient and Ambulatory Surgery CAHPS (OAS CAHPS).

***Responses to Comments about Burden on Facilities and Patients***

1. **Adding to burden of ASC reporting requirements and to patients.** Currently, OAS CAHPS is not required. A voluntary reporting period will begin in 2016. If a Rule is put in place for OAS CAHPS, consideration will be given to other existing accreditation standards and the overall burden on ambulatory surgery centers will be considered. With respect to patient burden, the current version of the survey is 2 minutes shorter than the version that was field tested in 2014. That 10-minute version yielded a 45.6% adjusted response rate, which further indicates the patients' willingness to provide feedback.
2. **Allow multiple survey administration options to ensure ASCs can choose the most affordable approach for their facility.** ASCs can choose an administration mode (mail only, telephone only, or mixed mode) which they believe is the best approach for their facility. Were ASCs to use an approach in which they played a more direct role with the patients surveyed — such as through on-site distribution of surveys or through conducting the survey themselves through a survey-focused unit —their involvement could introduce bias in the patient's responses. Based on our experience on other CAHPS® surveys, we have found that an independent third party (such as a survey vendor) will be best able to solicit unbiased responses to the OAS CAHPS survey. In addition, CMS' survey administration guidelines to which survey vendors must adhere ensure uniformity across all surveys nationally which is critical for the comparability of providers' results
3. **Cost to facilities to prepare and submit files of patient data to survey vendors is inaccurate:** The cost to facilities has been updated in the OMB package to reflect a similar amount reported for both Hospital CAHPS and Home Healthcare CAHPS. The collection of the patient's perspectives of care data for similar CAHPS® surveys follow the same model where providers pay the approved survey vendors for data collection and CMS pays for the survey vendor approval process, survey vendor training, technical support and assistance to vendors or hospitals and home health agencies, monitoring and oversight of the vendors and data analysis and public reporting of the survey data.

Currently CMS has not approved any vendors for the OAS CAHPS survey. However, as on other CAHPS® surveys, CMS strongly recommends that HOPDs and ASCs shop around for the best cost value before choosing and contracting with a CMS-approved survey vendor to conduct the survey on their behalf.

4. **High cost to solicit feedback from all patients:** Please note that HOPDs and ASCs are welcome to solicit feedback from all patients but CMS does not require it. Note too that the use of a random sample would ensure that patients sampled for OAS CAHPS are representative of the universe of patients thus making it unnecessary to sample all patients.
5. **Multitude of CAHPS surveys create undue burden on patients and health care systems:** There is no currently mandated experience of care survey for outpatient and ambulatory surgery facilities. Other CAHPS® surveys are appropriate for other settings but are not appropriate for HOPDs and ASCs.

***Responses to Comments about the OAS CAHPS Questionnaire regarding whether patient experienced outcomes and received discharge information about outcomes***

6. **Question 16, consider referring to pain that was unmanageable.** The question as currently worded simply refers to “pain as a result of your procedure.” From a methodological perspective, adding the qualification “unmanageable” could introduce unwanted variance as individuals’ assessments of what is manageable would vary from person to person. This question follows a question that asks if the patient was given information about what to do if he or she had pain during recovery (Question 15). For reporting results, OAS CAHPS analysis will only focus on patients who report having pain after leaving the facility (Question 16) if they indicate they were not given information about what to do if they experienced pain (Question 15). The intent of the question is to not learn whether the patient experienced pain but to learn whether the patient experienced pain and was not given discharge information about controlling pain. The facility is responsible for including discharge information about controlling pain if there is a possibility that the patient might have pain as a result of the procedure.
7. **Question 18, consider adding “...or subsequent use of pain medication” as a third example of reasons for nausea and vomiting.** While it is true that pain medication can be a cause of nausea and vomiting, the use of pain medication by a patient after discharge is not something that is within the facility’s control. The patient could have taken a medication that was not prescribed by the doctor at the facility. As with the previous comment, the intent of this question is not to learn whether the patient experienced nausea or vomiting but to learn whether they experienced nausea or vomiting and was not given discharge information about it.

8. **Question 20, consider adding “...in which you sought further consultation” to reduce the reporting of the bleeding.** This question and its predecessor (Question 19) are similar to Questions 15 and 16, in that the initial question asks if the patient received information about an outcome—in this case, bleeding as a result of their procedure—while the next question asks if the outcome took place. As noted previously, reporting of bleeding at question 20 is only problematic if the response to question 19 indicated the patient was not given discharge information about what to do bleeding occurred.
9. **Question 10, consider dropping lead-in statement, “Anesthesia is something that would make you feel sleepy or go to sleep during your procedure.”** During the survey development, focus groups and cognitive interview results indicated the need to clarify the term anesthesia to ensure all respondents understood the term.
10. **Question 16, consider changing pain question to avoid negative reports.** This question is analyzed in conjunction with its predecessor, Question 15. See Response #13 for a detailed explanation of the reporting plans.
11. **Question 13, discharge instructions:** We reiterate the response provided to the December 2013 CMS-10500 notice. As noted in that response, we accept that written discharge instructions are required per ASC Conditions for Coverage. However, our testing showed that sometimes the instructions given to patients were generic and not tailored for, or specific to the respondent’s individual situation, and therefore not helpful. Please note that Question 13 focuses on whether the discharge instructions included instructions that the patients needed.
12. **Questions 15, 17, 19 and 21, consider consolidating into one question about “problems as a result of your procedure.”:** While CMS appreciates the need to address relevant topics across the outpatient and ambulatory surgery industry, we believe that the four main topics covered in questions 15 through 22 (pain, nausea/vomiting, bleeding, and signs of infection) are the most universally appropriate and are critical to addressing patient experience of care related to recovery. As explained in Response #6, the initial question (such as Question 15, which asks if the patient was given information about what to do if he or she had pain) is reported with the second question (such as Question 16, which asks if the patient had pain). The two questions together provide feedback to facilities if their patients are not getting sufficient information about what to do if they experience these specific problems as a result of the procedure (or anesthesia, in the case of nausea or vomiting). Replacing these four specific topics with one generic question about “problems” would not provide patients with sufficient specificity to facilitate recall of possible issues or concerns. If facilities are interested in tailoring additional follow-up questions related to other outcomes, such as blurry vision or inability to void, the procedures for OAS CAHPS allow for additional questions to be included by the vendor implementing the survey.

13. **Question 16, 18, 20, and 22, consider removing these questions as they have little utility.** There is no expectation that a facility would take action based on the responses to Questions 16, 18, 20, and 21 alone. CMS does not intend to report these outcomes as stand-alone measures but only as an indication of the need for providing information about what to do if these outcomes occur as a result of the procedure. As we have noted previously, the purpose of these questions is to learn whether the patient was unprepared to handle any of the outcomes noted because the facility did not provide the necessary information prior to the patient leaving the facility.

*Responses to Comments about the OAS CAHPS Questionnaire regarding other questions*

14. **Question 1, consider rewording the question to reflect the patient being given “...all the information wanted or needed/wanted.”** The current wording tested well during cognitive interviews and during the field test in 2014. Changing the focus of the question to address all the information the patient *wanted* might come to include information that would not be within the facility’s control. The facilities are responsible for providing information that the patients need to know before the procedure. As the commenter writes, patient satisfaction may be related to the patient getting all the information they *wanted* but OAS CAHPS is a patient experience survey (not a patient satisfaction survey) and as such is keyed to events.
15. **Questions 26, 34 and 35, consider removing these questions because they are non-essential and not part of the patient mix adjustment:** We are in the process of identifying patient-mix adjustment factors to apply to the OAS CAHPS sample. This is part of the purpose of the mode experiment scheduled to start in fall 2015. As part of the analysis of the data collected from the mode experiment, CMS will determine the most appropriate questions to use as patient-mix adjustment factors. However, we would like to point out that other CAHPS® surveys are currently applying question 26 (HCAHPS) and a variation of question 33 and 34 (HCAHPS) as part of their patient-mix adjustment factors.
16. **Question 37, consider removing this question about assistance provided in completing the survey:** Please note that proxy respondents are not permitted for OAS CAHPS. It is fine for others to assist the patient in responding to the questions but we want the patient to formulate the answers to the questions themselves as best as they can. Question 37 is designed to tease out instances where someone other than the patient formulated a response. Note that because proxy respondents are not permitted, Question 37 is not included in the telephone version of the questionnaire.
17. **Questions about nurses and doctors (e.g. Question 7 and 9) are grouped together rather than presented separately as in HCAHPS:** Doctors, nurses, and other staff at the facility are grouped together in OAS CAHPS for two reasons. 1) This helps reduce

the overall length of the survey so that similar questions are not repeated separately for doctors and nurses. 2) The questions under section II, III and IV (facility and staff, communications, and recovery) include aspects of the patient's care that could be addressed by either the doctor or someone else at the facility. The combined format allows the patient to report that someone provided information and explained the process without having to recall the specific individual who gave the information. This is important because the OAS CAHPS focuses on the facility, including all the staff that work at the facility. For this reason, it makes sense to ask these questions in a way that reflects doctors, nurses, and other facility staff combined.

18. **Questions about pain should be the same as H-CAHPS:** HCAHPS Questions 12 and 13 are focused on pain management required for an extended stay (such as is typical for a hospital visit), which is appropriate for HCAHPS but not for OAS CAHPS. Question 14 from HCAHPS would not be an appropriate question for every scenario for outpatient and ambulatory surgery. The questions in OAS CAHPS about pain are focused on the patient receiving information about what to do if he or she had pain during recover (Question 15) and if the patient had pain as a result of the procedure (Question 16). See Response # 2 for additional explanation of these questions.
19. **Information for Question 1 and 2 is provided by the doctor:** These questions include aspects of the patient's procedure that could be addressed by either the doctor or someone else in the facility. The combined format allows that patient to report that someone provided the information without having to recall which specific individual provided the information.
20. **About You questions are too long:** The "About You" section includes questions that must be included in the survey to meet federal data collection requirements and questions that CMS will use to adjust publicly reported data. Please note that we are in the process of identifying patient-mix adjustment factors to apply to the OAS CAHPS sample. This is part of the purpose of the mode experiment scheduled to start in fall 2015.

***Responses to Comments about the OAS CAHPS Questionnaire regarding other questions – methodological issues***

21. **Utilize a consistent response scale within survey and across CAHPS surveys; use a 4-point response scale.** We appreciate that some facilities may participate in multiple CAHPS® surveys and we can appreciate the desire to compare across different surveys that utilize similar response scales. However, please note that this type of comparison is not the primary intent of the CAHPS® surveys. A significant difference between OAS CAHPS and most of the CAHPS® surveys (for e.g. HCAHPS, HHCAHPS, CAHPS

Hospice and ICH CAHPS) is that most patients' do not receive care from the HOPD or ASC on a regular basis or on a recurring basis. For most patients' their interaction with the facility on the day they received the outpatient surgery or procedure (which is the focus of OAS CAHPS) amounts to only a few hours. This is why a "never/sometimes/usually/always" response scale that may imply a more extended interaction with the facility is not used in the OAS CAHPS survey. The current 3-response item scale tested well during cognitive interviews in 2014.

**22. Yes/No responses should be replaced with "always, usually, sometimes, never"**

**response sets:** To address the comment regarding the "yes/no" response set, please note that similar to the HCAHPS questionnaire, this response set is used with questions that use the wording "did you" (for example, see question 10, 12, 19 and 20 of the HCAHPS survey). It is appropriate to use the "always, usually, sometimes, never" response set when a question includes the phrase "how often." The OAS CAHPS survey questions refer to a single point in time reference for an outpatient surgery or procedure and as such, the questions and response options are worded appropriately for this situation.

**23. Question 24, consider reversing the order of the response options to list positive responses first.**

Question 24 has a 10-point scale and follows the convention of ascending from negative to positive. This question tested well during cognitive interviews during the field test in 2014. Question 24 is consistent with other CAHPS® surveys.

***Responses to Comments about Length of Survey for Patients***

**24. Survey is much too long, increases cost, and negatively impacts response rate:** Based on our experience during the field test, the survey tested well and there were very few (~5) complaints about the length of the survey. In fact, we achieved a 45.6% adjusted response rate using the mixed-mode (mail with telephone follow up) survey. This compares favorably to response rates on other CAHPS® surveys. The current version of the survey reflects the removal of 12 questions that had been included in the version that was field tested in August 2014. The estimated burden was therefore reduced by 2 minutes from 10 to 8 minutes. CMS does not believe that the length of the survey is a significant burden to respondents.

***Suggested new Questions***

**25. Use of email and web-based survey administration:** We certainly appreciate the data provided to support the use of email or a web-based survey administration mode. While email and a web-based survey are not available survey modes at present, CMS is actively investigating these modes as possible new options for the future. As part of this

investigation, CMS inquired about current email coverage for patients among the facilities participating in the field test and found that adequate email coverage was not consistent and sample bias could be a result. As part of the current work in advance of the Mode Experiment in 2015, literature reviews are underway to better inform the implementation plans for OAS CAHPS. Also, CMS has tested new modes for the HCAHPS Survey, specifically a Speech Enabled-Interactive Voice Response mode and a Web-based mode, but concluded that issues stemming from differences in response rates and mode effects across implementations make such modes unsuitable for the HCAHPS Survey at this time; see “A Randomized Experiment Investigating the Suitability of Speech-Enabled IVR and Web Modes for Publicly Reported Surveys of Patients’ Experience of Hospital Care.” M.N. Elliott, et al. *Medical Care Research and Review*, 70 (2): 165-184. 2013.

26. **Open-ended question for patient’s written comments:** For national implementation of the OAS CAHPS, CMS will allow addition of supplementary questions to the survey such as a question allowing patients to provide comments.
27. **Patient safety questions:** We understand the desire on the part of ASCs to learn from their patients about patient safety, yet we reiterate the response provided to the December 2013 CMS- 10500 notice. As noted in that response, we were not able to develop questions about actions that patients could uniformly observe. For example, patients might not be able to observe all occurrences of whether staff washed their hands, nor might they be able to observe all instances of nurses checking bands before administering medications. As such, negative reporting might not be a true indication of any error by staff at the facility. As mentioned above, facilities can work with their vendor to add supplemental questions to the OAS CAHPS surveys. In that way, the ASCs and HOPDs would be able to include patient safety questions which are appropriate to their specific facility.
28. **Questions about new medicine:** We assume that the commenter was referring to Questions 15, 16 & 17 on the HCAHPS survey which are about medicines the patient had not taken before. The types of medicine that an HOPD or ASC would prescribe are mostly pain related to assist the patient in their recovery from the surgery or procedure, and Questions 13 and 15 capture information about whether the patient received discharge information about medications.. Questions probing the area of new medications are not included in the survey in the interests of length.

### ***Suggested Changes to Procedures***

29. **Pediatric patients:** We understand the desire on the part of ASCs to learn from their pediatric patients, yet we reiterate the response provided to the December 2013 CMS-10500 notice. The survey and the expected administration procedures would not be appropriate for pediatric patients. Parents would need to respond for pediatric patients. Please note that proxy respondents are not allowed, although respondents are able to ask others for help with reading the questions or scribing the answers. Further, the nature and phrasing of questions aimed at pediatric patients would be different from those aimed at adults. Questions appropriate for pediatric patients would ask about provider communication differently, for example, or would include more directed questions about reassurance and comfort.
30. **Data from surveys are not available in a timely manner.** In order to ensure consistent and appropriate sampling and implementation, CAHPS® surveys require a survey vendor to implement the sampling and data collection. The timing for receiving patient records, selecting the sample, administering the survey, and public reporting of results is based on the need for consistent reporting across all participating facilities. Despite the delay in public reporting, however, HOPDs and ASCs may have more immediate access to their individual results from their vendor after the completion of the survey.
31. **Accessibility for visually impaired.** CMS is aware of the need for this accommodation and is investigating appropriate avenues to address concerns. For OAS CAHPS, facilities that include patients who are visually impaired would be encouraged to work with a vendor to implement the telephone version of the survey.
32. **Distribution of the survey at the point of care:** To produce statistically valid results, the OAS CAHPS must select patients using a random sampling method. Distributing the survey at the point of care could potentially result in a non-random sample such as a convenience sample which could bias results. Note that implementing a random sampling method where surveys are distributed at the point of care will increase the burden on HOPDs and ASCs because 1) they would be required to attend training on sampling methods 2) they would need to comply with various monitoring activities such as site visits from CMS's contractor, 3) they would need to ensure that only eligible patients with eligible surgeries were given the survey, and, 4) they would need to calculate sampling rates, distribute surveys daily, monitor sample yields, and adjust the sampling rate according to yields. This extra burden on the facility is unnecessary. These are some of the types of considerations that CMS took into account when we introduced the third-party vendor model



### *Importance of OAS CAHPS*

33. **Importance of collecting feedback from customers to promote improvement.** CMS appreciated this indication of support for the OAS CAHPS survey.
34. **Importance of feedback from patients:** Thank you for your support of the survey and sharing your experiences. CMS agrees that a patient experience of care survey is an important opportunity for patients share their feedback on experiences of care.