

Certificate of Need – ASF Rules

Notes for Workshop #1 – August 17, 2015

WAC 246-310-270

- *Definition of “mixed use” referenced in current methodology:*
“Mixed use” operating room is not defined in statute or WAC. The department relies on the common definition of “mixed use” (in-patient and out-patient). Data for mixed use comes from hospital surveys and quarterly hospital reports. Variations in mixed use interpretations are reflected in submitted surveys. Discussion included removing isolated mixed use rooms and retaining dedicated rooms in methodology.
- *Data sources/collection:*
Challenges exist in the collection of hospital and ASF survey data. The department relies on data self-reported by ASF and hospitals in surveys and quarterly reports. Inconsistencies are inherent in this method of data collection. If entities do not return surveys or otherwise report data, the department turns to internal systems (ILRS) to retrieve data. Concern was expressed that hospitals could control OR capacity reporting, subsequently influencing existing capacity values and creating difficulty for ASF to show need. Concern was further noted that hospitals use OR for outpatient and other procedures, and reporting this may cause need to be depressed under current methodology. The department recognizes the imperfections of the current methodology, including the need to update to consider endoscopy centers, eye, and other specialty surgery centers. Discussion included whether national standards or default surgical use rates exist, whether hospital OR should be included in the methodology, whether minutes influence calculations, and whether the department should explore options other than self-reported data. General consensus was to run the current methodology under several different scenarios.
- *Planning Areas*
Discussion focused on the concept that planning areas can be affected by survey responses, creating unusual variances in use rates and affecting projections. Some planning areas have a higher concentration of healthcare facilities, although this is not a reflection of population growth – it is representative of where patients go to receive care and consequently, where need exists. Discussion included purposeful migration, in/out migration and the need to count it. Concern was expressed that urban need is underestimated while rural need is overstated.
- *Capacity/Access/Economic Efficiencies*
Variation exists not only in the definition of capacity, but in the way operating rooms are used based on the type of case. Discussion included whether to define ASF and ASC with respect to calculating capacity, and counting outpatient hospital capacity. Access related to choice was discussed in the context of offering outpatient alternatives in both rural and urban areas. Economic efficiencies were discussed as to hospital billing flexibility, outpatient surgical rates, Medicare reimbursement rates, DRG and bundled payments, cost control and affiliation.