



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

WASHINGTON STATE
CERTIFICATE OF NEED PROGRAM
Meeting Summary – Ambulatory Surgery Rule
WAC 246-310-270

A meeting regarding the Certificate of Need (CoN) ambulatory surgery rules convened on April 13, 2016. The meeting was held at the Department of Health, 111 Israel Road SE, in Town Center 2, Conference Room 158, Tumwater, WA 98504.

PRESENT: Frank Fox, Swedish/Providence
Susie Tracy, WASCA
Renee Howard, Perkins Coie
Christine Kiefer, Harborview/UW Medicine
Nick Shepard, MultiCare Health System
Jody Carona, HFPD
Zosia Stanley, WSHA

STAFF PRESENT: Bart Eggen, Executive Director
Janis Sigman, Program Manager
Beth Harlow, Analyst
Kathy Hoffman, Policy Analyst

9:05AM – Open Meeting

- Welcome, introductions, agenda overview, issue/topic/consensus tracking document review. No comments. - Kathy Hoffman

Presentation: ASF Survey Results

- Kathy presented and discussed ASF survey results.
- Generally, group did not expect wide variance in reported data tracking systems and minute tracking between facilities, but some anticipated this result.
- General agreement that these results *may* present challenges when moving to need methodology calculation.

- Revisited purpose of survey and group desire to know more about how ASF data reporting capabilities. Many found survey helpful. One participant found no useful purpose for survey.
- Discussion of alternate data sources if ASF data reporting capabilities are as varied as survey suggests. Group does not view how ASF collect data as incorrect or insufficient; just acknowledged reported variances and now brainstorming how to move forward.
- Discussion of what should be in or out of methodology based on survey. Jody requested a run of cross tabs on data for further comparison and analysis. Might remove variance if CoN-approved ASC and non-CoN approved ASC are compared.
- Move to discussion of ASC as extension of physician's clinic vs those used specifically for surgery – may explain variance in survey results.
- Licensed vs. non-licensed ASC – entities used for this survey were licensed ASC pulled from ILRS; number of non-licensed ASC is small. Since this is a small number, likely will not have significant impact on the number of surgeries performed.
- Group continues to discuss survey responses, data representations, and discusses variability. Kathy will cross-tab survey responses by CN and no-CN, by buckets. Cross-tabbing will flush out what questions we need to focus on for the methodology. Will also help us figure out minutes, hours of operation.
- Survey confirmed idea that group had early in the process with respect to consistency in surgery minute types – one size does not fit all; that that applying an average number of minutes to the methodology may not be of value.

Presentation – Quarterly Hospital Reports

- Jan and Kathy shared quarterly hospital reports for various hospitals that report to the department through CHARS. There are many data elements reported. Among them are total inpatient surgeries and outpatient surgeries. The year-end report includes a roll-up of inpatient and outpatient surgery minutes. Just an example of what is available in the way of data through CHARS.
- Is this information supportive of how group would parse out what total OR capacity is or would be for a hospital?
- Group discussion regarding how to determine how much of existing hospital OR space should be attributable to outpatient OR. Should we just ask? Most hospitals report their OR use as mixed. Would it be simpler to create a methodology that asks what are outpatient procedures and set a default time for each [procedure]?
- Idle capacity discussion: Most hospitals don't build excessive OR capacity, but what happens to cause it? Could be when default minutes are used in methodology.

- CHARS data is split by revenue codes; may be able to break these down by into buckets by ICD9 codes, similar to ASF survey for even comparison. Group explores what buckets might be, level of detail required; whether minutes reported will be a reflection of what surgery is and market. However, OR in hospitals are reported as mixed use.

Discussion: Proposed Hospital Survey

- Group moves toward defining buckets for hospital survey. Group prefers a similar representation of what the ASF are doing to be able to make a reasonable comparison on both sides.
- Agreement that outpatient surgery and ASF buckets should be the same.
- Agreement that GI, endo, and pain are separate buckets. Eyes and dental are, as well.
- Question to hospital might be: Based on these buckets, or concepts of procedures, can you give us a general, average minutes per surgery?
- Need to clearly define buckets in survey, make it easy for hospitals to get codes, minutes associated with codes, and calculate average time – very similar to what was done with ASF survey.
- Brief discussion of capacity and not meeting capacity projections, minimum utilization.
- Brief discussion of survey timing, feedback on buckets. Work group wants quick turnaround on survey elements to take to their organizations. Kathy will provide in three or four workdays. Kathy will create a single-pager that identifies buckets considered, types of facilities that are going to fall within those buckets, all-other or general category will include podiatry, ENT, ortho, some of these others. Pain, eye, dental all broken out. Workgroup members will take back, to organization, provide department with feedback on the buckets, and then from there, workgroup will develop what our questions are for our survey.

Discussion: Pediatric Outpatient

- Discussion regarding pediatric definition, age range, exceptions to general concept of pediatric care.
 - Since methodology includes everyone (“population”), should there be a separate methodology for pediatrics? Most kids treated in hospitals, not ASF
- **CONSENSUS:** Add something to the rule to address pediatrics as an exception that would allow the provision of pediatric ASF services to be considered as an exception to numeric need.

Discussion: Methodology

- Methodology generally works, but problem is with survey data.

- Agreement to reduce OR threshold from 2 to 1.
- Inpatient surgery projections: why needed? Because it impacts the number of OR available to perform outpatient surgeries. Discussion regarding whether this projection is still needed if we are moving to strictly outpatient. Group explores retaining mixed use concept.
- Group reviews current methodology template; reviewed mixed use, whether there would be a differentiation between dedicated outpatient and mixed use, or if estimated outpatient would suffice. Should this be a question in the survey – do hospitals limit their mixed use OR? Possibly replace mixed use with term “hospital based”? Data could possibly be collapsed into one total. Inpatient surgeries will impact the hospital’s ability to perform outpatient surgeries, and the survey may help group to flush out and understand the ratio. Then, the ratio could be applied to the methodology. Might cause rates to go down. Fewer ORs would be projected. Frank agrees to run a test of the methodology applying these concepts.
- Planning horizon discussion: Does it matter if we go to a longer planning horizon? Inpatient/mixed use OR will trump outpatient OR capacity since the outpatient surgeries can be done elsewhere, but the inpatient surgeries can’t, there will always be more inpatient surgeries regardless of length/type and this impacts the total number of outpatient surgeries performed in inpatient OR that are used for both inpatient/outpatient.
- Alternatively, review planning area inpatient minute trends, subtract five future years estimated inpatient minutes and use that as a percentage of total OR, then use that as available outpatient minutes. The second option is a benefit because it contemplates actual minutes as opposed to trying to determine what the estimates are across varying surgery and facility types. Minutes would need to be updated annually although some facilities operate on a fiscal year – could convert to calendar year. Would also need to define what minutes are.
- Will need to see the results of hospital survey – whether minutes can be merged, combined, etc., but conceptually, we agree that we’re going to make an assumption about a single operating room’s capacity, and that our methodology will be based on that.
- Hospital survey will help group align like-type ambulatory surgical procedures in a hospital that have similar times to freestanding ASF, and this will help group create new minute calculations.
- Will have to return to discussion of differences in minutes for like-type surgeries to consider inherent variances between ASF and hospital outpatient surgeries.
- Group discusses existing rule with respect to differences between hospital and ASF minutes (44 hours vs. 37.5 hours respectively). Testing the methodology will help group determine if these hours should be reconsidered.
- Idle capacity: freestanding specialty ASF may not need to operate more than a couple of days a week but it appears capacity does not look like it

is being met. How do we account for and reconcile this? If capacity isn't being used and it appears there is demand, should we count full capacity?

- Group agrees that further discussion regarding methodology can wait until hospital survey is conducted and results are analyzed. Methodology needs to be tested.

➤ **GENERAL AGREEMENT:** Proposed focus for methodology is on outpatient ORs (these are outpatient ORs that are not dedicated or mixed use whether they are in a hospital or not). These are all treated the same within the methodology. Need to test various methodology models and see how they work.

Conclusion:

- May 10 meeting canceled.
- Kathy will prepare single page document framing proposed hospital survey buckets and distribute to workgroup within 3 – 4 days of meeting. Members will distribute to their organizations for feedback and return to Kathy to assist in drafting survey questions.
- Assuming responses are timely provided, survey should be complete by the next meeting scheduled for June 8.