



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 November 19, 2015. 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
Lisa Everson, WASCA
Susie Tracy, WASCA
Ana Anderson, Perkins Coie
Christine Kiefer, Harborview/UW Medicine
Nick Shepard, MultiCare Health System
Emily Studebaker, WASCA
Lori Aoyama, HFPD
Ross C. Baker, Virginia Mason

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

9:15AM – Open Meeting

Agenda Items #1 and #2

- Welcome, introductions and brief agenda over view - Kathy Hoffman

Agenda Item #3

- Presentation: Analysis of Use Rate Options Including NCHS – Frank Fox
- Frank reported out on NCHS (National Center for Health Statistics), NHAMC (National Hospital Ambulatory Medical Care Survey), and MEPS (Medical Expenditure Panel Survey), providing analysis of the strengths and weaknesses of each data source.

- Second best approach was discussed. CHARS could be used, although an outpatient counterpart does not exist. Frank prepared a handout containing the following suggested data elements:
 - Number of ORs, set-up and in use, by facility
 - Information that distinguishes ORs by major type of use, including general surgery, and surgeries/procedures in special purpose rooms, e.g., eye surgery ORs, endoscopy suites, pain management rooms, dedicated open heart ORs, C-section, cystoscopy and trauma surgery rooms
 - Total number of cases, defined for inpatient or outpatient cases
 - Where appropriate, separated for special purpose rooms, as defined above
 - Total number of minutes, defined for inpatient or outpatient cases
 - Where appropriate, separated for special purpose rooms, as defined above
 - Responses provided on an annual basis for all licensed surgery facilities
 - Defined coverage period, e.g., most recent prior year
 - Defined submission period
 - Submission of survey responses a requirement conditioned on new and on-going licensure
 - The department timely compiles data, prepares it and releases a “standard” electronic data set that includes the above-defined data elements.
 - Annual compilation, preparation and release of data sets

Group Discussion

- Discussion of how to define “outpatient cases.” Hospital data does not have information by individual OR, but can provide inpatient and outpatient minutes, along with a calculation of the number of inpatient/outpatient cases.
- Principle of needing to understand OR utilization in terms of inpatient/outpatient is important, but how that is done may not be as straightforward.
- Discussion of inpatient/outpatient designation. ICD-9 and ICD-10 codes do not identify whether service is outpatient. Should assumption be that based on volume of inpatient/outpatient services, that room is one or the other?
- The group touched briefly on differing concepts of medical necessity (insurance definition vs. provider definition) and how data reporting may be impacted.

- Discussion of weighting vs. minutes or a combination of both. Lisa indicated that her ASC bills by procedure code, not minutes. Questions followed regarding what to ask entities to report.
- Capacity vs. utilization discussion: group wants to parse out certain case types from methodology where substantial differences are evident in data, specifically those where turnover is less than hospitals. A difference in how data is captured and how to account for it was discussed.
- Use rate was discussed as it relates to projections and what data to use to create use rate.
- **General Agreement.** Surveys are the best vehicle for gathering data. “Bucket level” data can tell us what entities do; we can create buckets around general surgery (everything other than certain procedures, all else); create global kinds of use rates. Use rates would then be set by data. Each reporting period would change.

Agenda Item #4 – Wisconsin Data – Nick Shepard

- Nick reached out to the Wisconsin Hospital Association, specifically the WHA information center. Wisconsin collects inpatient discharge, emergency room, ambulatory surgery and other outpatient data from hospitals. It also collected data from freestanding ASC pursuant to Wisconsin statutes.
- Nick will report out with more information as it becomes available.

Agenda Items #6 and #8

- Discussion resumed with respect to data collection, including case vs. procedure, whether hospitals use CPT-4 for reporting, and challenges of filtering complex data from hospitals while ASC may provide data that cannot be filtered.
- Goal is consistency in data collected from ASC and hospitals for purposes of equal comparison.
- **Decision** to survey providers first to ascertain whether challenges exist in providing data representing all surgical procedures performed along with specific data elements.
- Discussion of state wide rate vs. planning area rate. If we ask for zip codes in the survey, these can be tied to CPT codes.
- Discussion of surgery minutes and turnaround time. Hospitals determine this by billing codes or by units of service. In current rule, billing units is defined. Discussion of inpatient and outpatient cleanup and measures of efficiency.
- Discussion of case vs. procedure, elements of survey, and conceptualizing questions. Even if entities provide estimates, it will assist group in calculating capacity.
- Mechanics of survey administration discussed, along with potential assistance from group in survey messaging.

- **Group Consensus:** Survey should focus on procedures, location and time.
- **Group Consensus:** The difference between a case and a procedure is that a case may represent someone who received multiple procedures. A case is measured from the time the patient entered the OR and the time the patient left the OR.
- Surgery suite vs. procedure room discussion. Procedure can be surgical by definition. For CoN purposes, it is an OR. Might not look like the same surgical environment, but it's still an OR and we count those (like GI labs and pain programs). Hybrid OR? Survey perspective and capacity perspective are different

Conclusion

- Survey will include the following questions (concepts):
 - Provide CPT-4 coding
 - Can the provider tie patient zip codes to procedure codes (patient origin data)
 - Minutes/time it takes to do their average procedure (case level – patient in room/patient exit room)
- Draft questions will go to workgroup for review and response.
- Agreement to cancel December 10 meeting.